

Community Access Initiatives

Overview of Community Access Initiatives and Targeted State Actions for Support

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Community Access Initiatives

Overview of Community Access Initiatives and Targeted State Actions for Support

Executive Summary

The HRSA-funded Washington State Planning Grant on Access to Health Insurance includes a focus on Washington State communities that are considering or have embarked on efforts to significantly improve access to health services for their residents. The project seeks to identify and describe local access initiatives and to analyze and—where opportunity, need, feasibility, and interest exist—identify ways the state can help enhance the success of these community efforts. This report is presented to the program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the consultant team.

The universe of local efforts to improve access is very broad, encompassing everything from hospitals seeking short-term operating capital to stay afloat to fundamental restructuring of health care financing and delivery. To establish a scope of work that could be accomplished within the grant's resources, we confined our focus to those community efforts that are intended to substantially “transform” their health care delivery and financing systems and that involve or offer opportunities for partnerships between the public and private sectors.

The ideas emanating from communities in Washington are, indeed, novel and (at least potentially) transforming. For example, a few community initiatives attempt to make the complex insurance eligibility system “invisible” to individuals and families, so that they receive necessary services regardless of changes in their income, health, or employment status. Others have devised creative mechanisms to blend the financial or service delivery strengths of otherwise disparate organizations (e.g., Indian tribes and community hospitals).

As originally conceived, this project component sought to identify (in relation to community access initiatives) areas for a state role, areas where local action only is appropriate, and areas where local-state cooperation is essential for the completion of a task. To accomplish these objectives would require that the local activities were far enough along in their thinking and planning to be able to identify specific state actions that would be beneficial. In learning about community access initiatives in Washington State prior to and during the State Planning Grant process, we found that they are in a variety of stages of development:

- *Conceptual*—In some cases, organizations and community leaders are involved in discussions about key issues and potential approaches to address these issues, but have not yet developed specific projects or initiatives to implement.
- *Project development*—Some local efforts have set priorities and defined specific projects they wish to develop; they may have also obtained funding to support planning and

implementation activities. Most community access initiatives discussed here are in this stage of development.

- *Program implementation*—A few community initiatives have developed a series of interventions to improve access, often with a vision of how the individual projects fit together to solve multiple access problems; individual projects may be in various stages of development, from conceptual to implementation. The few community initiatives in this phase have obtained significant outside funding to support planning and implementation.

Few local efforts have reached a level of development at which they could specify desired state administrative, regulatory, or statutory changes. However, the findings and analyses in this report do suggest a number of state actions that could strengthen state-community collaborations, facilitate partnerships to improve access, and support local initiatives. Each would require additional investigation of its efficacy and its statutory, regulatory, financial, and administrative feasibility.

- Create a “Community Access Ombudsman Office” that could act as a single point of contact for communities, promote state-community partnerships, or advocate for the interests of community access initiatives regarding funding opportunities and with state agencies.
- Identify and collaborate with community and provider access partnerships that involve: information sharing to promote timely enrollment and connection with needed services; care management pilot projects; joint work by agency medical directors and local providers on utilization issues, network adequacy, and HIPAA implementation; and use of retired dentists to serve low-income people.
- Investigate alternative contracting models for Medicaid and Basic Health services, including decentralized models developed with selected community access initiatives.
- Develop a single focus for communities and providers for state health policy, possibly building on the governor’s health subcabinet.
- Promote administrative simplicity by investigating: the use of “smart card” technology; a single point of entry or unified application for Healthy Options and Basic Health; quicker, less contentious adjudication and payment of claims; and designation by the governor of all rural areas as HPSAs.

Community Access Initiatives

Overview of Community Access Initiatives and Targeted State Actions for Support

Background and Overview

Local communities in Washington State have a long history of proactive involvement in shaping their health systems and addressing specific issues such as access to health services. Over the past four decades, organizing efforts and leadership in numerous communities have helped to create federally funded community and migrant health centers and local-tax financed public hospital districts, both now critical in assuring access to health services in nearly every corner of the state. From the early 1970s through the mid-1980s, regional comprehensive health planning agencies and, later, the state's four federally funded health systems agencies were active forums for community stakeholders to discuss and create plans for local health system development. Other important local efforts have focused on recruiting and retaining health professionals, creating community care networks (often involving local business and political leaders), and strengthening public health and health promotion efforts.

Rising costs, eroding access, disruptions in health insurance markets, financial instability among health care providers, and general dissatisfaction with managed care have once again spurred local communities to consider creative initiatives. A collaborative effort to improve access and care quality in the Spokane region has received support from The Robert Wood Johnson Foundation's Communities in Charge grant program (see www.communitiesincharge.org). That effort and four access initiatives in central and southwest Washington and King County have also received federal HRSA Community Access Program (CAP) grants (see <http://bphc.hrsa.gov/CAP>).

In addition, the Washington Health Foundation has an array of programs that support access initiatives at the community level (see www.whf.org). The Rural Health Viability Grant Program provides funds that keep struggling health facilities open in rural Washington. The Future of Rural Health is designed to support community-led efforts to transform local health systems and to spur other communities toward similar efforts. The Foundation is developing tools and information to assist such community efforts and hopes to provide demonstration project funding to one or more collaborations beginning in 2002.

Purpose of Community Initiatives Component of the Grant

The HRSA-funded State Planning Grant on Access to Health Insurance (SPG) includes a focus on Washington State communities that are considering or have embarked on efforts to significantly improve access to coverage and to health services for their residents. The project seeks to identify and describe local access initiatives and to analyze and—where opportunity, need, feasibility, and interest exist—identify ways the state can help enhance the success of these community efforts. Mutual understanding of the issues faced, solutions contemplated, and flexibility and accountability needed are part of this work. This report is presented to the

program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the consultant team.

To define a manageable scope within the State Planning Grant, the consultant team had to limit this part of the effort to some subset of all community-level access projects. The focus on "transformative" initiatives (see Methods section, below) provides a workable focus, but it is not meant to judge whether some community efforts are more worthy than others.

In fact, communities across the state are taking a variety of important actions to improve or preserve access for their citizens through such vehicles as the Department of Health's Critical Access Hospital and Health System Resource Grant programs, and the Washington Health Foundation's Rural Health Viability Grant and Future of Rural Health programs. Information about these programs and their grantees is presented in Appendix A.

In addition, other important and innovative local efforts address targeted issues or diseases. For example, the REACH 2010 Coalition in King County, with funding from the federal Centers for Disease Control and Prevention, is focused on reducing diabetes health disparities experienced by communities of color. Through local partnerships, "the Coalition supports the empowerment of individuals, families, and communities, and creates sustainable long-term approaches to prevention and control of diabetes."

The balance of this document presents the findings and implications of the project's focus on community access initiatives. As part of the community access initiatives component, the consultant team collected and synthesized descriptive information about ten community-level access initiatives—eight in Washington State and two from other states—that *illustrate* the kinds of broad efforts being undertaken:

- Colville Tribe / Grand Coulee Hospital Collaboration (North Central Washington)
- Community Choice HealthCare Network (Wenatchee/Central Washington)
- Inland Northwest in Charge Initiative (Spokane/Eastern Washington)
- Jamestown S'Klallam Managed Care Program (Clallam and Jefferson Counties)
- Kids Get Care (King County, Washington)
- Northeast Washington Medical Clinics (Northeastern Washington)
- 100% Access Project (Central, Western Washington)
- Rural Health Reform Workgroup (East Jefferson County)
- Arkansas River Valley Rural Health Cooperative (Northwest Arkansas)
- Rural Wisconsin Health Cooperative (Rural Wisconsin)

These descriptions can be found in the next section. In addition, we conducted a targeted needs assessment—to gather feedback from the perspectives of communities involved in access initiatives—regarding barriers to and opportunities for state-local partnerships and any administrative, regulatory, or legislative changes or flexibility that would be supportive of community initiatives. This assessment, beginning on page 12 below, reveals potential actions the state could take to support or work with communities that are developing or implementing projects.

Methods

The community access initiatives component of the State Planning Grant on Access to Health Insurance included two activities, the development of an *overview of selected community initiatives* and a *community needs assessment*.

The universe of local efforts to improve access is very broad, encompassing everything from hospitals seeking short-term operating capital to stay afloat to fundamental restructuring of health care financing and delivery. Any type of activity can be very important, even critical, for any particular community. It would not have been possible to address all such efforts—of which dozens may be conducted at any one time—given the resources available within the State Planning Grant. Therefore, to define which community access initiatives to focus on, the consultant team relied on two sets of guidelines. First, the Request for Proposal for the HRSA project noted interest in initiatives “that include alternative models of community-based delivery and financial flow arrangements that partner private and public purchasers with the local communities and their health care delivery systems.”

Second, the consultant team and SPG staff met with Washington Health Foundation staff to explore synergies between the Foundation’s Future of Rural Health (FRH) initiative and the State Planning Grant. The discussion revealed that both projects were interested in local efforts that were “transformative” in nature, whose goals are to change fundamentally how the local health system is financed and organized, not simply to solve a specific access issue or plug a specific hole in the system. Since FRH had already developed a set of 10 criteria that seemed consistent with the HRSA grant, the consultant team decided to use the FRH criteria *as general guidance*.

The first five FRH criteria focus on the internal characteristics of a well-functioning system, characteristics that are “important to creating the cohesiveness and spirit to serve the health care needs of a community over the longer term.” The second five are broad indicators essential to the success of any health system:

- Transformational in nature
- Community-based and locally driven
- Organizationally linked and accountable
- Cooperative
- Publicly supported and individually acceptable
- Affordable and cost-efficient
- Accessible coverage and care
- Focused on improving quality
- Aimed at health status improvement
- Sustainable in the long term

With these criteria in mind, the consultant team reviewed FRH, CAP, and Communities in Charge grantees in Washington State, based on information available from their Web sites as well as from the projects themselves. We did not apply the FRH criteria in any rigorous process, but rather looked for local initiatives whose characteristics seemed generally consistent with the

criteria as a whole and that would provide an illustrative range of such efforts. With some guidance from FRH and Washington State Planning Grant on Access to Health Insurance staff, we selected eight community access initiatives in various stages of development across the state. In addition, we selected two community-level initiatives from outside Washington State—one is in northwest Arkansas and one is in rural Wisconsin—based on work HPAP previously performed for FRH and for the Robert Wood Johnson Foundation regarding its Southern Rural Access Program.

Overview of Selected Community Initiatives

In consultation with the Washington State Planning Grant on Access to Health Insurance project team, we developed a template with which we sought to provide consistent information on each community initiative (the information for each community initiative, in Appendix B, is presented within this template). For each of the 10 community access initiatives, we collected written material provided by the initiatives and supplementary information available on their Web sites; in one case, information was only available orally. After completing the templates, we sent them to the respective community organizations or contacts and asked that they verify or correct the information. Information about the two non-Washington initiatives had been verified previously. These initiatives are presented here as *illustrations* of the various types and scopes being undertaken by community organizations, providers, and coalitions; an exhaustive inventory was not possible within project resources.

Community Needs Assessment

We collected information about barriers to and opportunities for local-state partnerships and potential state actions to support community access initiatives, as perceived by community projects themselves, from three sources:

Communities That Won't Wait (CTWW) Caucus—This group is an informal, periodic gathering designed to provide an opportunity for information sharing and mutual problem solving among four community access initiatives in Washington State and various interested agencies, organizations, and individuals. HPAP acts as the convener and facilitator of the caucus. The CTWW meeting on September 27, 2001, focused on local-state partnership issues and opportunities.

Washington Health Foundation—WHF's Future of Rural Health (FRH) program is designed to support the efforts of local rural communities working toward fundamental change in the financing and delivery of health care. HRSA consultant and Washington State Planning Grant on Access to Health Insurance staff met with WHF staff on October 5, 2001, to discuss how the HRSA project and FRH activities could be mutually supportive, as well as WHF suggestions for how the state could support community access initiatives.

Community Access Initiatives—We contacted representatives of the eight community access initiatives in Washington to request their input into the needs assessment. We sought answers to the following three questions: 1) what specific barriers to working with the state are perceived by communities; 2) what types of assistance from or partnerships with the state are of interest to communities; and 3) what administrative, regulatory, or legislative changes or flexibility would be supportive of community initiatives. We obtained information from six initiatives, of which five provided specific answers to the questions about barriers and opportunities to community-state partnerships. In two cases, the consultant team obtained information by participating in a

meeting of local partners. One initiative was not far enough along to respond to the three questions.

We then identified themes and commonalities among the comments received and organized the input into four main categories: community-state relationships; state health policy development; state program goals and implementation; and provider relations and access. For each category, the consultant team made broad assessments of the feasibility of suggested state actions based on our experience and knowledge of state programs and agencies.

Overview of Selected Community Access Initiatives

Introduction

One of the HRSA Access Grant's objectives is to describe community efforts to maintain and strengthen access for their residents. This focus is timely, because some of the most innovative thinking and work on access around the country is being conducted at local or substate, regional levels.* In addition, the fragility and challenges of the health care financing and delivery systems can often be best understood at the community level.†

We developed an overview of community access initiatives by collecting descriptive information from 10 relatively broad-scope efforts—eight are in various regions of Washington State, one is in northwest Arkansas, and one is in rural Wisconsin. These initiatives are presented here as *illustrations* of the various types and scopes being undertaken by community organizations, providers, and coalitions.

The ideas emanating from communities in Washington are, indeed, novel and (at least potentially) transforming. For example, a few community initiatives attempt to make the complex insurance eligibility system “invisible” to individuals and families, so that they receive necessary services regardless of changes in their income, health, or employment status. Others have devised creative mechanisms to blend the financial or service delivery strengths of otherwise disparate organizations (e.g., Indian tribes and community hospitals).

As originally conceived, this project component sought to identify (in relation to community access initiatives) areas for a state role, areas where local action only is appropriate, and areas where local-state cooperation is essential for the completion of a task. To do so would require that the local activities were far enough along in their thinking and planning to be able to identify specific state actions that would be beneficial. In learning about community access initiatives in Washington State prior to and during the State Planning Grant process, we found that they are in a variety of stages of development:

* See, for example, The Southern Rural Access Program (www.hmc.psu.edu/rhpc) and Communities in Charge Program (www.communitiesincharge.org) of The Robert Wood Johnson Foundation.

† See, for example, *Understanding the Changing Rural Health System Landscape in Washington State*, Washington State Department of Health (http://depts.washington.edu/hpap/Rural_Health/rural_health.html), 2000; and the *State Primary Care Provider Study*, Washington State Health Care Authority and DSHS Medical Assistance Administration (http://depts.washington.edu/hpap/Publications/PCP_Study/pcp_study.html), 2001.

- *Conceptual*—In some cases, organizations and community leaders are involved in discussions about key issues and potential approaches to address these issues, but have not yet developed specific projects or initiatives to implement.
- *Project development*—Some local efforts have set priorities and defined specific projects they wish to develop; they may have also obtained funding to support planning and implementation activities. Most community access initiatives discussed here are in this stage of development.
- *Program implementation*—A few community initiatives have developed a series of interventions to improve access, often with a vision of how the individual projects fit together to solve multiple access problems; individual projects may be in various stages of development, from conceptual to implementation. The few community initiatives in this phase have obtained significant outside funding to support planning and implementation.

Few local efforts have reached a level of development at which they could specify desired state administrative, regulatory, or statutory changes.

By their nature, *these innovative initiatives are fluid*, changing as local conditions or state or federal policies change and as trial-and-error leads to improved or different strategies. As a result, the reader should remember that the information contained in this overview was accurate at one point in time (roughly, winter 2001), but may not reflect where a community access initiative is at some point in the future. A summary table of selected community initiatives (Figure 1) is presented below; additional information for each model is included in Appendix B.

Figure 1: Summary Descriptions of Community Access Initiatives

Community Access Initiative	Lead Organization(s)	Scope (geographic, subpopulation, etc.)	Description	Purpose(s) and Expected Outcome(s)	Funding*
Colville Tribe / Grand Coulee Hospital Collaboration	Grand Coulee Hospital District / Colville Tribe, North Central Washington	Residents of the Grand Coulee Hospital District (Douglas, Grant, Lincoln, and Okanogan, counties) and the 7,933 members of the Colville Tribe.	Planning to replace the existing hospital and nursing home; tribe would supply capital, district would operate the facilities.	Improved access and service quality for Tribal members and district residents.	Internal
Community Choice HealthCare Network	Community Choice (Wenatchee)	Un- and underinsured residents in Chelan, Douglas, and Okanogan counties.	Various strategies to support providers and community members to facilitate enrollment in existing public programs and targeting resources to needs.	Various strategies to sustain community providers, expand insurance coverage, and improve clinical and patient information systems.	CAP
Inland Northwest in Charge Initiative	Health Improvement Partnership (Spokane)	Un- and underinsured residents of 11 counties in Eastern Washington.	Various strategies to facilitate enrollment in existing programs and use existing funds more efficiently, including outreach, care management, etc.	Expand access to existing resources; develop effective care management systems; improve patient referral and information systems.	CAP CIC
Jamestown S'Klallam Managed Care Program	Jamestown S'Klallam Tribe	Tribes contract health service area of Clallam and Jefferson counties and the 242 Tribal members.	Provides access through purchase or subsidies of public and private health insurance.	Assure access to all Tribal members by coordinating coverage, insuring all members, and providing wrap-around services.	Internal IHS Medicaid
Kids Get Care	King County Health Action Plan, Public Health-Seattle & King County	Children aged 0-5 in three communities of King County with a high concentration of un- and underinsured children.	Early screening for physical, oral, and developmental health status; linking children to health care homes through local providers and community organizations.	Assuring that children receive basic health care services regardless of insurance status and improving children's health status through a focus on early prevention.	CAP Other grants
Northeast Washington Medical Clinics	Colville Medical Group and Mt. Carmel Hospital	North Stevens, Pend Oreille, and Ferry counties, ~35,000 people.	Creation of a not-for-profit corporation (NE WA Medical Clinics) to integrate and manage outpatient ambulatory care.	Improve efficiency, quality, and coordination of rural health services.	Internal
100% Access Project	CHOICE Regional Health Network	93,000 residents <250% FPL in Grays Harbor, Lewis, Mason, Pacific, and Thurston counties.	Various short term survival and long term sustainable strategies, including outreach, care management, etc.	Coordinated access to uniform set of services; coordinated funding; sustainable providers.	Internal CAP WHF Other grants
Rural Health Reform Workgroup	Jefferson County Public Hospital Dist. #2 / Jefferson County Board of Health	Residents of eastern Jefferson County.	Community process to identify effective strategies to maintain and improve access.	Access for all area residents and a sustainable system of health service providers.	Internal WHF
Arkansas River Valley Rural Health Cooperative	Arkansas River Valley Rural Health Cooperative (Paris, Arkansas)	45,000 residents of Franklin, Logan, and Scott counties; ~6,000 non-elderly uninsured.	Plans to provide access to basic health services through local providers using a wrap-around catastrophic insurance product.	Cover 50% of non-elderly uninsured (~3,000 people).	Internal
Rural Wisconsin Health Cooperative	Rural Wisconsin Health Cooperative	28 rural acute, general hospitals and their communities in south-central and mid-state Wisconsin.	Cooperative supports health organizations through management services such as credentialing and data collection, and seeks and manages grants for multiple organizations.	Advocates for rural health and supports providers through clinical/management services and managed care contracting.	Internal

*Internal: Internally generated revenues, such as dues; CAP: HRSA Community Access Program; CIC: The Robert Wood Johnson Foundation Communities in Charge Program; WHF: Washington Health Foundation; IHS: Indian Health Service.

Community Needs Assessment

As described in the Methods section, above, we sought information from eight community access initiatives in Washington State regarding barriers to and opportunities for state-local partnerships to improve access and, if possible, specific actions the state could take to support community initiatives. Given available resources, this needs assessment is based only on the views of this group of community projects, not all community access efforts; in addition, we did not collect similar information from representatives of all state agencies that might or do have contact with local projects.

The major findings from the needs assessment are presented below and in a matrix in Appendix C. We then present implications of these findings for possible state actions to support community access initiatives.

Major Findings

Taken together, the information from these sources falls into four general categories—Community-State Relationships, State Health Policy Development, State Program Goals and Implementation, and Provider Relations and Access—under which we summarize the major barriers and opportunities as perceived by community representatives. For each category, we also include an assessment in light of existing state and federal responsibilities.

Community-State Relationships

Barriers

Community representatives perceive various types of barriers in the way state agencies approach working with communities.

- Perhaps most typical of these concerns is the view that the state treats community organizations and service providers as vendors not as partners in serving people.
- The state seems reluctant to partner with community initiatives, for fear of appearing to favor one locale to the detriment of others or because it's easier to administer a one-size-fits-all program. Sometimes, state staff seem overly cautious due to state rules concerning conflicts of interest, ethics, competitive bidding, public meetings, public disclosure, and use of public funds for private gain.
- Community initiative staff find it difficult getting timely, useful, and consistent responses to requests for information or assistance from and across state agencies. Rather than seeing such requests as opportunities for creative dialogue, state staff give *yes* or *no* responses.
- Representatives of communities, especially those in rural Washington, voiced concern that key state agency staff do not have a working understanding or appreciation of local conditions.

Opportunities

We heard a number of possible state actions or approaches that might improve community-state relationships and better support community access initiatives.

- The state could provide staff of DSHS, DOH, HCA, and other agencies with a single set of guidelines for how to interpret regulations regarding conflicts of interest, ethics, competitive bidding, public meetings, public disclosure, and use of public funds for private gain.
- In collaboration with communities, the state could develop a cooperative agreement to formalize and define the scope of partnerships with community access initiatives, including points of mutual accountability and criteria and mechanisms to “fast track” partnership development. This effort could result in a process through which the state could “waive” certain requirements for communities that are willing and able to assume greater control and accountability. Models of such agreements that could be looked at include DOH-local health department consolidated contracts, USAID Cooperative Agreements, and intergovernmental agreements (in the case of public hospital districts).
- Specific HCA and MAA staff could become formal, active participants in the implementation and governance of the four HRSA Community Access Program-funded community initiatives. More generally, state staff could be encouraged to become active participants in community access initiatives, perhaps rotating through organizations involved in such initiatives, in order to expand their knowledge of how local health systems work.
- The state could create an ombudsman office or function that can facilitate, across state agencies, communication and the development of partnerships with community access initiatives; this idea is, in some ways, similar to the Washington State Office of Trade and Economic Development’s Washington State Business Assistance Center or the role the DOH Office of Community and Rural Health plays on rural health issues.

Assessment

The thrust of these five possible opportunities is to seek ways for state agencies and state government, as a whole, to more aggressively support and participate in local initiatives to promote access. To do so would require the state to address at least three issues:

- The tension between two important and legitimate goals: assuring fairness and equity across all communities and recognizing unique circumstances and characteristics of specific communities and regions.
- The different missions, statutory requirements (state and federal), and cultures of the various health-related agencies of state government.
- Budget limitations that may require agencies to make choices between allocating resources to statewide versus community level activities.

Washington State has a history of health sector activities that involve state agency direction and that allow for regional or local differences. Both the Healthy Options and Basic Health programs began with pilot projects that involved state-local (and private sector) collaboration in some parts of the state but not others. The AIDS Nets and Regional Support Networks are state health policies implemented in such a way as to allow considerable variation from region to region in how HIV/AIDS prevention and mental health services, respectively, are planned and delivered—within guidelines and with oversight from state agencies (Department of Health and Department of Social and Health Services, respectively). These examples have not been without considerable tensions and conflicts and have required considerable resources for ongoing negotiation and

problem solving. In addition, in each of these examples, the goals and specific expectations for the state-local partnership were relatively clear and targeted (e.g., in the case of the BH, contracts were to be signed with health plans and a pre-defined set of benefits were to be provided to a pre-defined population).

Likewise, state agencies in Washington have long had, and continue to have, staff working in and with organizations and service providers in communities across the state. Since its inception, DOH has emphasized its relationships with local public health agencies, relationships that run the gamut of contractual, technical assistance, regulatory, and collaborative. Likewise, DSHS has Community Service Offices across the state, the Department of Labor and Industries has regional staff who provide consultation to local businesses on workplace safety, and the Office of the Insurance Commissioner has local SHIBA representatives. So, questions about what state staff can and can't do within these contexts and relationships probably come up with some frequency.

A single set of guidelines concerning each rule or issue would provide some consistency and, therefore, facilitate reasonable expectations of agency staff activities on the part of communities. However, the types of interactions state staff have with community organizations and providers are wide-ranging—involving contracts, payment issues, regulatory matters, technical assistance, consultation—making it difficult for a single set of guidelines to cover all (or even most) potential issues or circumstances. Moreover, each state agency has its own statutory framework, which means that somewhat different interpretation of state rules may be necessary.

Two state agencies provide “ombudsman” or “clearinghouse” models that could help to address some of the challenges and take advantage of some of the opportunities concerning community—state relationships.

- The Washington State Office of Trade and Economic Development (OTED) offers two programs specifically designed to assist local communities and businesses. OTED's Community Economic Assistance Center (CEAC) forms partnerships with communities and organizations to improve economic conditions and stimulate private and public investment. To assist local projects, the Center works with local economic development councils, local and tribal governments, downtown associations, and community economic development organizations as well as state and federal agencies. Through these relationships, the state provides financial support, training, and technical assistance. CEAC philosophy is to: encourage local determination of economic development priorities; collaborate with partners at all levels to move local projects to implementation; simplify access to resources; and make and leverage appropriate investments when projects are ready to proceed.
- OTED also operates the Washington State Business Assistance Center (<http://edd.cted.wa.gov/bac/bizinfo/default.htm>), including a statewide toll-free telephone service providing information and referrals regarding starting or operating a business in Washington. Among the resources available through the Center is help identifying and connecting clients with appropriate state agencies for regulatory and other matters.
- The Washington State Department of Health's Office of Community and Rural Health (OCRH, www.doh.wa.gov/hsqa/ocrh/default.htm) is viewed by rural health activists as a primary point of contact with the state. Its mission is to “assure rural and underserved urban communities, American Indian tribes, groups, and individuals have the necessary resources to define and then achieve better health.” OCRH staff often work with other state agencies

(e.g., DSHS, HCA) to advocate for the interests of rural communities, acting as an ombudsman or “navigator” within the Executive Branch on behalf of those communities.

- DOH also has instituted “consolidated contracts” with local public health jurisdictions. These contracts address mutual accountabilities and expectations across a range of public health programs and activities, yet are intended to allow for local variation in how program outcomes are to be achieved. The consolidated contracts were intended to lead to performance-based contracts, but that has not yet been instituted.

State Health Policy Development

Barriers

Community representatives raised concerns about an apparent lack of focus in state health policy among the various health-related agencies (e.g. DOH, DSHS, HCA, OFM) that sometimes results in inconsistent guidance depending on which agency is contacted. In addition, they said that the state does not regularly involve local providers and community leaders in discussions of state policy issues and decisions, which can lead to actions that are not sufficiently sensitive to local conditions.

Opportunities

Those participating in this needs assessment offered two major suggestions that might make it easier for communities to have input into state health policy discussions and to communicate with state health policy makers.

- The state could more clearly vest responsibility for and leadership in health policy in one agency, to provide a single focus for communities and others outside of state government.
- The governor’s office could create a formal mechanism (e.g., an advisory panel similar to the BH advisory committee) for involving local providers and community leaders in discussions of state policy issues and decisions.

Assessment

The challenge of vesting “responsibility for and leadership in state health policy in one agency” is not insignificant. Each of the major health-related agencies (DOH, DSHS, HCA, OIC, and L&I) answers to different state statutory requirements, federal rules and guidelines, and stakeholder constituencies. Their missions—and therefore the programs and staff they deploy—are quite varied, as are their political contexts. For example, the insurance commissioner is an independently elected office, while the other agency heads are appointed by the governor, and L&I operates as a partnership between business, labor, and state government.

A number of strategies to coordinate the “voice” of the state have been tried. The 1993 Health Services Act created the Washington Health Services Commission with a wide range of planning and regulatory authorities. During its short existence, the Commission was a primary focus for addressing state policy problems, especially because it had responsibilities for carrying out many of the Act’s provisions. Its successor, the Health Care Policy Board, likewise was a central forum for discussing health policy issues, but it did not have the regulatory authority that allowed it to speak on behalf of the various state agencies. The governor’s health subcabinet provides an ongoing vehicle for coordination and communication among state agencies; since most agencies

are accountable directly to the governor, this committee has considerable potential for helping the state speak with one voice. In addition, the governor's health policy adviser(s) in OFM has often been the primary contact point for statewide and local stakeholders for issues that cut across individual agency responsibilities.

As defined by their authorizing statutes, the membership of the Health Services Commission and Health Care Policy Board were representative of various public and private stakeholders. Thus, they were formal structures for involving these stakeholders and others in state health policy discussions. As the community informants noted, the BH advisory committee also provides an ongoing, consistent way for stakeholders to have input into decisions that affect the BH and its constituencies. Another formal structure for policy involvement is the labor-management committee that advises L&I; it is viewed as a critical part of the department's decision-making process by all major stakeholders.

Having a defined advisory committee structure would provide community leaders and local providers with a consistent process for learning about and providing input to state health policy developments. It would also allow state agencies to learn about local concerns and perhaps vet possible strategies to allay those concerns and improve program activities. However, such an advisory committee would require dedicated staff resources to be reliable and successful, which may be difficult to come by in the current state budget environment. In addition, to be manageable and effective, such an advisory group must not be too big; as a result, some community organizations or local providers may not have "a seat at the table" and would have to rely on the same indirect input as might be available now. Finally, a governor's health policy advisory panel may have too wide a scope and may well duplicate existing committees such as the BH advisory council, the L&I labor-management committee, and others.

State Program Goals and Implementation

Barriers

Community representatives identified perceived issues regarding overall goals of state programs—most notably Basic Health and Medicaid/Healthy Options—and aspects of their implementation.

- Various comments reflected a belief that HCA and MAA are more focused on health plan contracting than access to services, *per se*. In this view, the agencies have abrogated their role in assuring continued provider participation and become too dependent on managed care contracting, which is perceived as having failed in some communities.
- The separation of and distinction between the major state health programs, especially Medicaid and Basic Health, are viewed as resulting in unnecessary administrative complexity, duplication, and burden, confusion for both clients and providers, and a significant loss of federal revenue. In addition, the separation makes it difficult to see how, for example, PEBB provider payment policies affect the willingness of providers to participate in BH and Healthy Options.
- Community organizations involved in facilitating enrollment in Basic Health and Medicaid are concerned that they do not receive adequate, timely information to allow them to improve and target their outreach and client/care coordination efforts.

- Although the Health Professional Shortage Area and Rural Health Clinic programs are viewed as helpful and important, the application and designation processes are viewed as cumbersome.

Opportunities

Ideas to improve state-community collaborations ranged from the general to the specific.

- The insurance commissioner’s office could work with community access initiatives that seek to develop responsible alternatives to traditional health insurance products. Such efforts may require alternative means of assuring financial solvency or relief from mandated benefits.
- The state could merge the management of BH and Medicaid or, short of that option, create a single point of entry and single application process for all BH and Medicaid programs.
- The state could designate a responsible community organization as a quasi-local HCA/MAA office to allow it to determine, or at least track, eligibility, enrollment, and re-enrollment for BH and Medicaid clients.
- The state could refocus the goals of BH and Healthy Options on client access and adopt the best contracting mechanism in each community or region to achieve that goal. This shift could require state agencies to take some additional financial risk, for example through the provision of reinsurance, or allow them to participate in innovative models, such as regional purchasing cooperatives.
- HCA and MAA could work with selected community access initiatives and related health plans to provide local organizations with timely data about state clients they work with, in order improve tracking and coordination of services. Such data could include client name, date of enrollment/re-enrollment/disenrollment, date of service, provider of service, and expenditures.
- MAA and HCA could use “smart card” technology—similar to the food stamp program within DSHS—to reduce the administrative burdens of eligibility determinations.
- The governor could designate all rural areas in Washington as Health Professional Shortage Areas, thus facilitating the designation of medical practices as Rural Health Clinics.

Assessment

The first three opportunities, above, are specific, optional *outcomes* that one or more communities may seek in partnership with the state. Their common objectives are to simplify how state programs are experienced by local communities and to make use of the capacity and expertise of local organizations and providers in improving how these programs are implemented. We believe these objectives are shared by community organizations, providers, and state agencies, alike.

Each of these three options would entail significant state or federal legal, administrative, and fiduciary changes that would have to be investigated. The scope of this project does not allow an in-depth analysis of these issues, nor can we determine how each might fit with important developments such as the state’s Medicaid waiver request or potential budgetary decisions by the Legislature. However, one of the functions of an ombudsman for community access initiatives (see discussion of Community-State Partnership, above) might be to investigate, from both

community and state perspectives, the desirability, appropriateness, and feasibility of these strategies. At this time, not every community access initiative is interested in each of these alternatives. In addition, it may be that different strategies than those suggested here could better meet the shared objectives suggested above.

Opportunity concerning the goals of BH and Healthy Options is also complex. The legislative intent of both the Healthy Options and Basic Health programs refers to improving access for individuals with certain income and insurance coverage characteristics. Both also set contracting with managed care organizations as the desired method for financing and organizing health care services for these target populations. State agencies have a responsibility to address both tenets; the question those interviewed in this project raise is: Which is paramount? Both the HCA and DSHS have already faced this issue as health plans have decided whether to participate in these two programs, leaving some communities with fewer than the desired two health plan options. In these cases, Medicaid has offered primary care case management as an optional model.

Are other models, perhaps those developed by communities themselves, also possible—perhaps superior—as alternatives to the traditional managed care model? Again, significant state and federal regulatory issues would need to be studied to answer this question. A number of factors suggest the time is right to try:

- The RWJF Communities in Charge, HRSA’s Community Access Program, and Washington Health Foundation’s Future of Rural Health Program are evidence that support and interest in community-led access initiatives are of widespread interest and viewed as having significant potential.
- A number of communities in Washington have already demonstrated the interest, leadership, and willingness to invest resources in creative efforts to improve access.
- Though HCA and DSHS have had recent success in maintaining health plan choice in most areas of the state, state budget constraints may undermine these efforts and, again, make it difficult to maintain the sustained participation of enough health plans.

Sharing data with community access initiatives entails issues of confidentiality and administrative feasibility. Federal and state laws govern the use and allowable users of client data in health programs, and HIPAA further complicates this picture. For those community organizations or collaborations that are active in outreach to clients and facilitating enrollment, however, such information could greatly increase the effectiveness of their efforts—for example, through timely re-enrollment or connecting people with needed services—which would aid state programs, as well.

Likewise, smart card technology has the potential to reduce administrative complexity and costs for both clients and providers. A number of states have implemented such technology in their food stamp programs, so there is some relevant experience upon which state health insurance programs could draw.

Finally, the possibility of “blanket” HPSA designations could provide some higher level of predictability and somewhat lower administrative complexity than the current piecemeal approach. Health Professional Shortage Areas (and Medically Underserved Areas*) are used by

* MUAs are used for Community and Migrant Health Center designations, National Health Service Corps and J-1 visa placements, and training grants. These programs were not the focus of concern and discussion in the needs assessment and, therefore, are not addressed further in this document.

more than 37 federal programs to target federal resources, including Rural Health Clinic status, Medicare bonus payments, and telemedicine reimbursements. Washington has aggressively assisted local communities and providers in seeking designation: nearly 90% of rural areas of the state are already designated.* Designations must be renewed about every three years.

Federal rules allow the governor to designate broad areas as HPSAs using state-specific standards, subject to federal (HRSA) review. Although few new areas would be eligible for federal support, a designation by the Governor could provide “a more stable and systematic method of knowing which areas are eligible.”† In addition, the state would need to address three factors should it chose to pursue this option: 1) new proposed federal rules are currently under review; 2) RHC surveys have not been a high priority for the federal government, so designation, *per se*, may not quickly expand the number of medical practices that benefit from enhanced payments; and 3) enhanced payment that results from designation can have a significant effect on state expenditures.

Provider Relations and Access

Barriers

Most community access initiatives work closely with local service providers and, therefore, are well aware of the conditions under which they operate, how they relate to state programs, and whether local residents face barriers to getting care from these providers.

- Many local care providers feel they are constantly being asked to do more with less and are squeezed by: low Medicaid and BH payment rates; high administrative burdens to participate in state programs; a B&O tax that is levied even if they lose money; and the Medicaid physician audit program, which is viewed as onerous and ineffective.
- The state’s reliance on health plan contracts has led, in the view of community representatives, to a breakdown in communications and collaborations between state agencies and providers.
- Dental care access is threatened in some communities due to a lack of available providers.

Opportunities

Ideas to improve relationships between state programs and providers include:

- HCA and MAA could ask their medical directors to lead efforts to develop care management strategies and policies in partnership with providers and community organizations. This effort could entail co-development of pilot or demonstration programs to test innovative care management systems or approaches.
- MAA could drop the Medicaid audit program.
- State programs could increase provider payment rates.
- The state could provide technical assistance to providers on HIPAA implementation, including patient privacy provisions.
- State agencies could increase their direct communication with providers (i.e., not rely on health plan-provider relationships); for example, disseminating information to physicians

* Personal communication from Vince Schueler, DOH Health Care Access Analyst, November 9, 2001.

about use rates for categories of prescription drugs for which state spending is especially high or rising rapidly.

- MAA and HCA could monitor health plans for service quality and efficiency, not just network adequacy.
- The state could allow retired dentists to provide care to low-income individuals.

Assessment

These findings suggest four major areas that could address the actual or perceived problems regarding providers and access as reported by representatives of community initiatives: payment level, administrative burden, state-provider collaborations, and state-provider communications. These issues are of concern to community access initiatives, because providers are often major partners in those initiatives and because efforts to expand access rely, ultimately, on the willingness of providers to participate in them.

The supplemental budget passed by the state legislature does include rate increases for some health care providers, but projected budget difficulties over the next few years will make it difficult, at best, for DSHS or HCA to increase payments significantly. However, findings from *The State Primary Care Provider Study* in 2001 (http://depts.washington.edu/hpap/Publications/PCP_Study/pcp_study.html) suggest that reducing administrative burdens and complexity were of strong interest among providers who participate in Medicaid and BHP. The Administrative Simplification component of this project also revealed some possible administrative improvements, including electronic fund transfers for provider payments and a streamlined claims adjudication process that might reduce the number of delayed or challenged payments (i.e., by immediately paying all claims under some dollar threshold, such as \$50).

In addition, just as communities seek partnerships with the state (see discussion under Community-State Relationships, above), providers expressed interest in better relationships with state agencies. Given the complexity and importance of HIPAA and the potential benefits of collaborative care management strategies, these opportunities seem promising. Agency medical directors have put substantial effort into similar collaborations with health plans. If Medicaid or BHP managed care contracts experience another period of fluctuation or retrenchment, stronger relationships with local providers may help to mitigate any effects on enrollees and patients.

Some discussions in Lewis County have identified a number of retired dentists who could provide some minimal amount of care to low-income people. Concerns include skill level and issues of malpractice. The Washington State Dental Quality Assurance Commission and the University of Washington School of Dentistry could explore how to assure such dentists are up-to-date in their skills and are covered for malpractice.

Implications for State Action

The findings from and assessments of community feedback suggest a number of state actions that could strengthen state-community collaborations, facilitate partnerships to improve access, and support local initiatives. Each would require additional investigation of its efficacy and its statutory, regulatory, financial, and administrative feasibility.

- ***Community Access Ombudsman Office***—Potential activities of such an office might include: 1) acting as a single point of contact for communities seeking information from or partnerships with multiple state agencies; 2) promoting consistency across state agencies in their interactions with communities; 3) facilitating the involvement of state agency staff in community access efforts; 4) studying the potential for partnership agreements for collaborative programs and mutual accountability between the state and communities; or 5) advocating for the interests of community access efforts, including identifying or stimulating new funding opportunities (private, state, or federal) and working with state agencies to explore potential regulatory or administrative waivers or flexibility. If it pursues this option, the State should consider whether this function is best placed in one of the health agencies or in OFM.
- ***Community and Provider Collaboration***—Modest effort on the part of the state could identify and produce important collaborations that benefit access, including: 1) information sharing with those community initiatives that have active outreach and related client contact activities; 2) care management pilot projects; 3) more frequent communication between agency medical directors and local providers on topics such as utilization issues, network adequacy, and HIPAA implementation; and 4) the use of retired dentists to serve low-income people.
- ***Alternative Contracting Models***—As the managed care market has fluctuated, the HCA and DSHS have considered models for financing and service delivery that are alternative to their traditional health plan contracting. A few community access initiatives may offer these agencies an additional, decentralized model that may be worth testing.
- ***Focus for State Health Policy***—Of existing bodies, the governor’s health subcabinet has a broad enough membership to be able to act as the “voice” of state health policy. Alternative models are possible and could be considered.
- ***Administrative Simplicity***—Several areas that would simplify how communities, providers, and residents experience state programs appear potentially fruitful: 1) use of “smart card” technology; 2) closer coordination in the enrollment processes of Medicaid and BHP, perhaps through a single point of entry or unified application; 3) quicker and less contentious adjudication and payment of claims; and 4) governor designation of all rural areas as HPSAs.

Appendices

A. Descriptions of Public and Private Programs in Washington State that Support Community Access Efforts

B. Community Access Initiative Descriptions

C. Matrix of Needs Assessment Findings

D. Partnership with the State: Definitions

Appendix A.

Descriptions of Public and Private Programs in Washington State that Support Community Access Efforts

Critical Access Hospital Program Description

Washington State Department of Health

Health Systems Resources Grant Program Description

Washington State Department of Health

Rural Health Viability Grant Program Description

Washington Health Foundation

Future of Rural Health Program Description

Washington Health Foundation

Critical Access Hospital Program

Washington State Department of Health

November 2001 Status

Section 4201 of the federal Balanced Budget Act (BBA) of 1997 authorized the State Medicare Rural Hospital Flexibility Program, also called the Critical Access Hospital (CAH) Program. In December 1998, the Washington State Department of Health Office of Community and Rural Health (OCRH) submitted the State Rural Health Plan, which created a CAH program in Washington, to the federal Health Care Financing Administration. CAH designation provides for cost-based reimbursement for qualified, essential community hospitals, but also leads to a loss of any Medicare Disproportionate Share payments. OCRH is the lead entity and is responsible for designation of Critical Access Hospitals and coordinating related state approvals.

Thirty rural hospitals meet the federal 35-mile distance criterion, and 15 rural hospitals meet the state "necessary" provider criterion. Forty-four of the 45 hospitals are eligible for the program, since in one community two hospitals would be required to merge. Eligible hospitals must participate in the state Emergency Medical and Trauma System, at either Level III, IV, or V.

Hospitals designated by the state and certified for Medicare and Medicaid CAH payment

	Hospital	City	County	Start Date
1	Garfield County Memorial	Pomeroy	Garfield	August 1999
2	Dayton General	Dayton	Columbia	January 2000
3	Willapa Harbor	South Bend	Pacific	April 2000
4	Mark Reed	McCleary	Grays Harbor	July 2000
5	Lincoln	Davenport	Lincoln	August 2000
6	Deer Park	Deer Park	Spokane	November 2000
7	Coulee Community	Grand Coulee	Grant	January 2001
8	Odessa Memorial	Odessa	Lincoln	January 2001
9	St Joseph's	Chewelah	Stevens	August 2001
10	Newport	Newport	Pend Oreille	October 2001
11	East Adams Rural	Ritzville	Adams	January 2002
12	Prosser Memorial	Prosser	Benton	January 2002
13	Cascade Medical Center	Leavenworth	Chelan	January 2002

Hospitals designated by the state and preparing for the CAH Certification Survey

	Hospital	City	County	Survey Date
1	Ocean Beach	Ilwaco	Pacific	Not yet scheduled
2	Klickitat Valley	Goldendale	Klickitat	Not yet scheduled
3	Skyline Hospital	White Salmon	Klickitat	Not yet scheduled

Hospitals actively preparing for CAH designation by the state

	Hospital	City	County	Desired Survey Date
1	Ferry County Memorial	Republic	Ferry	Early 2002
2	Columbia Basin	Ephrata	Grant	Early 2002
3	Othello Community	Othello	Adams	Early 2002

Hospitals in process of conducting financial/operational analysis of CAH status

	Hospital	City	County
1	Quincy Valley	Quincy	Grant
2	Forks Community	Forks	Clallam
3	Morton General	Morton	Lewis
4	Lake Chelan Community	Chelan	Chelan
5	North Valley	Tonasket	Okanogan

Contact: Beverly Court, OCRH Critical Access Hospital Program Manager, (360) 705-6794, beverly.court@doh.wa.gov, www.doh.wa.gov/hsqa/ocrh/RHS/cah399.html.

Health Systems Resources Grant Program

Washington State Department of Health

The Health System Resource (HSR) Grant program (RCW 70.175 and 70.185, WAC 246-560), managed by the DOH Office of Community and Rural Health (OCRH), provides grants to for-profit, not-for-profit, or governmental entities that are acting on behalf of the population in a rural catchment area or acting on behalf of an urban underserved area (for recruitment and retention activities only). HSR Project goals are to promote affordable access to health care services to residents in rural areas of Washington State and to assure the availability of health care providers to residents of rural areas and to urban underserved populations.

Projects that are focused on assuring the availability of health care providers (recruitment and retention activities) require a 50% match and must serve places where problems with recruitment and retention of providers have been chronic, the community is in need of primary care practitioners, or the community has unmet health care needs for specific target populations.

Contact: Alice James, OCRH program manager, (360) 705-6769, alice.james@doh.wa.gov, www.doh.wa.gov/hsqa/ocrh/rhs/HSRprogram.htm.

Grantees 1999-2001

Affiliated Health Services

CBRR Grant

Point of Contact: Doreen DeLong, 360-629-58011, ddelong@affiliatedhealth.org

Grant Amount: \$35,000

Serving: Camano Island

New Clinic Start-up: Affiliated Health Services is opening a new rural health clinic on Camano Island a medically underserved area. There are more than 12,000 residents. Historically there have been no primary care services available on the island. The project will bring to the island the first primary healthcare services, as well as community outreach programs dealing with prevention and wellness. Specifically, the HSR funds will support costs of mid-level practitioner staffing, the development and implementation of a retention plan for the mid-level position, and the development and implementation of a wellness and prevention program with local churches.

Associated Provider Network

Point of Contact: Jere La Follette, 360-416-7099, jgl@apnnet.org

Grant Amount: \$26,000

Serving: North Sound Region of Washington

Developing a Comprehensive Acute Behavioral Health Care Plan for Children: This project will plan for an effective system of acute mental health services for rural children in the North Sound Region of Washington. APN is a network of all the community mental health providers in the region and, in a unique contract with the North South Regional Support Network (NSRSN), provides both inpatient and outpatient services to the Medicaid eligible population. The regional division of the Department of Children and Family Services (DCFS) is also a key partner in this project. Together, APN, NSRSN, and DCFS will reach beyond their own spheres of operation to

develop a system-wide children's acute plan. The project hopes to reduce children's hospitalizations, length of stay, high intensity placements, and recidivism after discharge.

Benton Franklin Health District

Point of contact: Laurie Ghigleri, 509-943-2614 x259, laurieg@bfhd.wa.gov

Grant Amount: \$45,000

Serving: Benton and Franklin counties

Dental Services for Benton-Franklin Counties: This program will provide a children's program for remote communities in Benton and Franklin counties, including dental assessments and sealants done in schools, with a referral process for more serious dental work, for approximately 100 students over a two-year period.

Community Health Council of Seattle-King County

CBRR Grant

Point of Contact: Meredith Vaughn, 206-324-9360, mereditv@sihb.org

Grant Amount: \$59,530

Serving: King County

Community Diabetes Initiative Self-Management Support Project: The goal of the project is to decrease the diabetes-related mortality rates in the region by training and supporting health care teams in the use of self-management support methods. Self-management support (SMS) is a proven method to encourage healthy behavior changes among people living with a chronic disease such as diabetes. The seven community health centers and the local health department are working together on several fronts to improve the care they give to people with diabetes, incorporating self-management support into their system of care for low-income people across King County.

Country Doctor Community Health Center

CBRR Contract

Point of Contact: Jessica Joyce, 206-461-4920, jjoyce@seanet.com

Grant Amount: \$54,165

Serving: The Central Area and Capital Hill neighborhoods and other underserved areas of Seattle and King County

Meeting the Mental Health Needs for Low-Income and Uninsured Individuals: Country Doctor is conducting a collaborative effort to expand mental health services to those most in need, the uninsured. This project provides salary and benefits for a full-time mental health care coordinator to provide accessible mental health services on-site at the Country Doctor Clinic.

Klickitat Valley Hospital Columbia Gorge Community Health Network

Point of Contact: Ron Ingraham, PhD, 509-773-4017, jeffteal@gorge.net

Grant Amount: \$60,626

Serving: Youth of Klickitat and Skamania counties in Washington, and Hood River and Wasco counties in Oregon

Columbia Gorge Teen Health Enhancement Project: The Columbia Gorge Teen Health Enhancement Project is a collaborative effort involving the four hospitals of the Columbia Gorge

to enhance teen access to health care and to prevent selected teen health problems. The Search Institute Developmental Assets model will continue as the theoretical base, but will use more locally developed materials and strategies. A major program change will be an emphasis on the collaborative development and maintenance of mentoring and volunteer programs in the communities, a direct result of survey data, youth and community input, and program evaluation findings. The Teen Council concept will be expanded to include more teens from each hospital district. The focus/projects of the councils will reflect the youth health needs and interests of the local communities. The Teen Summit is an annual opportunity for youth to learn about health concerns and resources, practice leadership skills, provide input for systems planning, and learn to function as positive role models.

Olympic Medical Center

Point of Contact: Laura Showers, 360-417-7652, lshowers@olympicmedical.org
Grant Amount: \$41,600
Serving: Clallam County

New Family Services at Olympic Medical Center: Olympic Medical Center's New Family Services (NFS) provides pre- and postpartum in-hospital teaching and referral. HSR funds support the start up a home visiting component: NFS registered nurses will offer a home visit to all postpartum women, regardless of insurance or income, and provide it within the first 48-72 hours of discharge from OMC. By providing in-home breast feeding support, infant care and parenting education, and early collaboration and referral with other agencies, the project hopes to increase breast feeding duration, decrease hospitalizations, and improve maternal and child health outcomes.

Quileute Tribe

Point of Contact: Barb Bocek, 360-374-7414, quileute@olympen.com
Grant Amount: \$50,340
Serving: Quileute Tribe

Quileute Health Department Business Operations Development: With this project, the Quileute Tribe hopes to improve the Health Center's third-party billing capabilities and generate sufficient additional revenues to support additional medical and dental primary care providers on the Reservation. Project activities include: 1) designing a program to monitor Health Center billings; 2) obtaining necessary staff training in billing procedures; 3) increasing billing revenues; 4) increasing budgeted funds for medical and dental provider staffing; and 5) sharing the results with other health center directors.

Samaritan HealthCare

CBRR Grant

Point of Contact: Scott Campbell, 509-766-7362, scampbell@samaritanhealthcare.com
Grant Amount: \$60,000
Serving: Grant County / Columbia Basin

Columbia Basin Physician Referral Tracking Program: The Columbia Basin Physician Referral Tracking Program is a pilot project to develop a system to track referrals from primary care physicians to specialty physicians. The purpose of the project is to improve communication between primary care physicians and specialists and, by doing so, to improve the continuity of

care for patients. Patients who are referred for services to larger communities often get lost in the system and lose contact with their local physician. This leads to unnecessary duplication of services and dissatisfaction for rural physicians, contributing to turnover and costly physician recruitment.

Snohomish Health District

Point of Contact: Judy Ward, 425-339-5230, ward@shd.snohomish.wa.gov

Grant Amount: \$27,270

Serving: Darrington

Oral Health, A Community Affair: This project focuses on health care access initiatives in the most rural corner of Snohomish County—Darrington. The goals are: to increase the number of children residing in Darrington who access dental care; to increase community knowledge and perceived value of dental care; to increase community linkage to Medicaid insurance; and to facilitate development of a community strategy to increase access to dental care for all Darrington residents. Activities include community member interviews, promotional campaign, facilitation of community discussions, and provision of dental sealants in the Darrington School.

Whidbey General Hospital

CBRR Grant

Point of Contact: Judy Moore, 360-678-7656, moorej@whidbeygen.org

Grant Amount: \$60,000

Serving: South Whidbey Island

Meeting the Health Needs of Underserved South Whidbey Residents: The South Whidbey Rural Health Community Center (SWRHCC) project provides primary care health services to low to moderate-income residents of South Whidbey Island. The need for these services has been well documented in community health assessments and the use of the hospital emergency room for conditions treated more appropriately in a primary care setting. The project provides for a physician assistant and clinical infrastructure. Several outcomes of the project will be an Operations Policy and Procedure Manual, a Communications Plan and outreach materials, and a local health resource list. Oversight and planning for the SWRHCC will be provided by an active community Advisory Board with members from area agencies such as schools, nonprofit organizations, and the county health advisory board.

WSU - College of Pharmacy

Point of Contact: Deborah Haberman, 509-358-7570, habermad@wsu.edu

Grant Amount: \$49,525

Serving: Clinic sites in Wenatchee, Othello, Okanagan, Moses Lake, Chewelah, and Spokane

Medication Assistance Partnership of Spokane (MEDS): MEDS's mission is to aid in the procurement of pharmaceutical medications for uninsured and low income. This part of the program is to develop a system to obtain pharmaceutical medications from pharmaceutical companies' indigent care programs.

Rural Health Viability Grant Program

Washington Health Foundation

Through the second cycle of the Rural Health Viability Grant Program, the Foundation will distribute approximately \$1,200,000 in grants to eligible rural providers. The goals of the Program are three-fold:

- To preserve access to local health services in rural areas by providing short-term support to vulnerable rural hospitals, providers and communities across the state
- To provide incentives for the development of long-term sustainable approaches in the future
- To provide support for collaborative approaches that sustain access to quality health care

The Foundation uses several criteria for awarding funds through this grant program, including financial vulnerability, community and system vulnerability, population vulnerability, and long-term sustainability. Grant awards range from \$15,000 to \$100,000. These grant funds have been made available through PROSHARE, a financing program designed by the Washington Health Foundation with the Association of Washington Public Hospital Districts and the Washington State Hospital Association.

Contact: Lorna Stone, Director of Rural Health, (206) 283-6122, Lornas@whf.org,
www.whf.org/grantrsvp.html.

2000-2001 Grantees

The Rural Health Viability Grant Program concluded its first cycle on March 15, 2000, awarding grants totaling \$600,000 to the following thirteen applicants:

Grantee	Amount	Purpose
Cascade Medical Center, Leavenworth	\$20,000	Strategic planning
Darrington Clinic	\$70,000	Primary care clinic
Deer Park Hospital	\$30,000	CAH feasibility studies
Garfield County Health District	\$43,000	I-695 losses (conditional)
Garfield County Transportation	\$16,000	Maintain patient transportation
Klickitat Valley Hospital	\$80,000	Improved coding and efficiency
Lake Chelan Community Hospital	\$55,000	Ambulance retrofit
Mark Reed Hospital, McCleary	\$36,000	Access program
Mattawa Community Health Clinic	\$10,000	Strategic planning
Northeast Washington Medical Group	\$80,000	Operational losses
Springdale Community Health Clinic	\$33,000	Purchase of double-wide trailer
St. Joseph's Hospital of Chewelah	\$75,000	Improve financial stability
Whitman County Public Health Partnership	\$52,000	Sustain public health standards

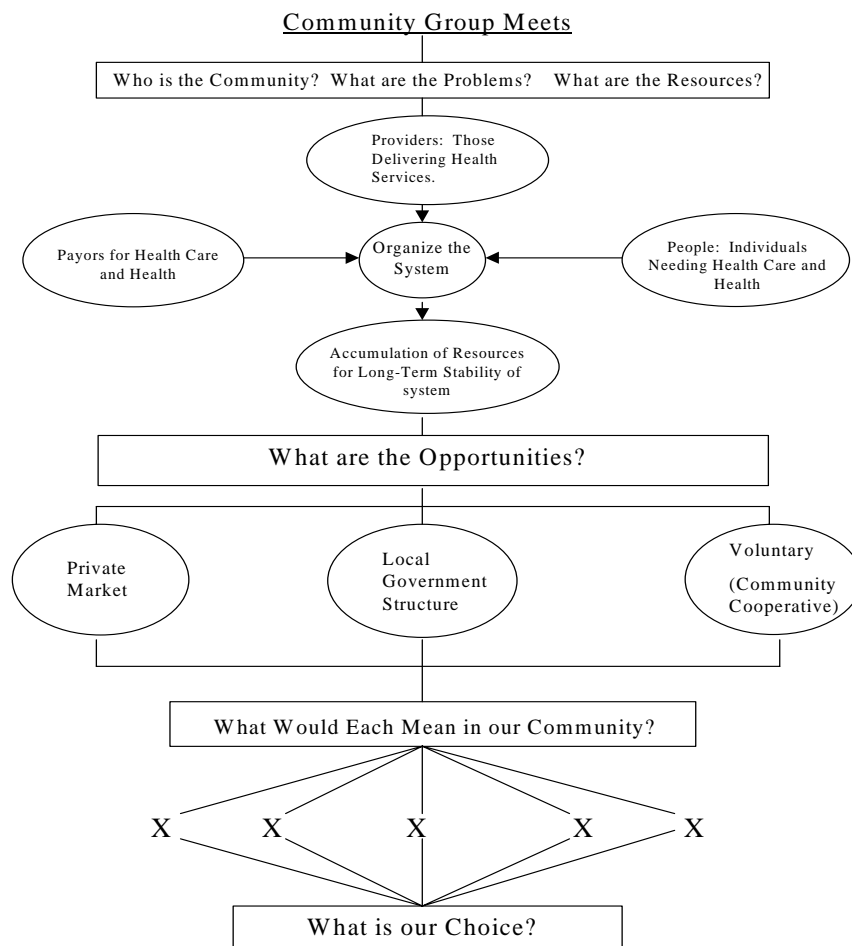
The Future of Rural Health Program

Washington Health Foundation

The Washington Health Foundation created the Future of Rural Health (FRH) program to stimulate the fundamental changes required to assure long-term viability of health care in our state's rural communities. FRH is envisioned as a five-to-ten year effort, with a focus on designing, supporting, encouraging, and testing new and more effective ways of organizing health care in rural communities. The program's components—leadership, education and analysis, local support, local dialogues, and local demonstrations—are designed to provide leadership toward system change, while engaging communities and rural health leaders at their own level of thinking and readiness for change.

The Foundation has developed a conceptual framework to describe both the challenges inherent in any health care system and its view of the range of solutions available for a longer term Future of Rural Health.

What Does it Mean "To Organize the System"?



Contact: Lorna Stone, Director of Rural Health, (206) 283-6122, Lornas@whf.org,
www.whf.org.

Appendix B

Descriptions of Selected Community Access Initiatives

Colville Tribe / Grand Coulee Hospital District Initiative

North Central Washington

Overview

The Colville Tribe / Grand Coulee Hospital District initiative aims to build a collaboration among communities in close proximity to one another, who can combine resources to make their health care system work more efficiently and provide enhanced services. The Tribe will seek federal dollars to build a new, replacement hospital; the Grand Coulee Hospital District (#6) will lease this facility from the Tribe. The purpose of this initiative is to maximize resources and increase access to health services for the target populations.

Goals

The goal of the Colville Tribe / Grand Coulee Hospital District collaboration is to improve the integration of care, access, and continuity of care for Tribal members and residents of the hospital district's service area.

Basic Description

The Colville Tribe / Grand Coulee Hospital District collaboration would involve building a new facility to replace the existing hospital and associated nursing home, possibly to be located on the Colville Reservation. The Tribe would use federal dollars to fund and build the facility and lease it to the hospital district.

Target Population

The target population are the residents of the public hospital district (Douglas, Grant, Lincoln, and Okanogan counties) and the members of the Colville Tribe (7,933 enrolled members).

Financing

The activities of the initiative would be funded through federal resources dedicated to Native American Tribes. The taxes paid by the members of the Grand Coulee Hospital District would continue to fund the basic operations of the hospital.

Unique Features

This collaboration capitalizes on the unique strengths of both organizations: the Tribe has better access to construction capital, and the hospital district is proficient in health care facility operations. This is a possible solution to the impact that the non-taxed tribal land has on the hospital district.

If the hospital were to be designated as an IHS Clinic, tribal members could receive primary care there rather than traveling an additional 16 miles to the closest IHS Clinic.

Governance

The governance structure for this initiative is still in the planning process.

Initiative Status

This initiative is in the early discussion phase.

Contact Information

Mel Tonasket, Project Consultant, (509) 826-4528, mct@bossig.com.

Community Choice HealthCare Network

Wenatchee, WA

Overview

The goal of this program is to increase access to health care for the uninsured and underinsured populations of Chelan, Douglas, and Okanogan counties.

Goals

The goals of the Community Choice Network are to:

- Locally define the uninsured/underinsured population and needs
- Establish a health insurance outreach program and increase enrollment of eligible families and individuals
- Expand clinical and patient information systems
- Establish local community reserve pools
- Establish community provider groups
- Develop and implement objective measurement systems

Basic Description

Community Choice is a not-for-profit provider network comprising physicians, hospitals, community, and other organizations. It serves its members through: health plan contracting, group purchasing contracts, member services/provider services, network-wide community assistance programs, grant applications and administration, and public education on health care issues.

Target Population

Community Choice is designed to serve the uninsured and underinsured populations of Chelan, Douglas, and Okanogan counties.

Financing

Community Choice is funded by a HRSA Community Access Program (CAP) grant that provides funding of \$900,000 through July 2002.

Unique Features

One unique feature of Community Choice is the development of community provider groups, which will aid in case management of uninsured patients, assist in enrolling the un- and underinsured in state and federal programs, manage the community reserve pools, and evaluate where needs exist for specific types of providers throughout the community.

Community Choice contracted with Health Facilities Planning and Development of Seattle, Washington, to conduct a public opinion survey of residents in Chelan and Okanogan counties. Information was collected on health insurance coverage, demographics of the uninsured, perceptions and effect of being uninsured, utilization and perceptions of the local health care system, and ideas for Community Choice.

Governance

This access initiative is led by the Community Choice Board of Directors. The Board is composed of physicians, hospital administrators, and community representatives. Community Choice has also created partnership relationships for various projects with several partners including CHOICE Regional Health Network (Olympia), Chelan-Douglas and Okanogan county health districts, DSHS offices, social services agencies, school districts, and state and federal legislators.

Initiative Status

Community Choice is fully funded and is in the implementation stage.

Contact Information

Tom Jones, Executive Director, (509-665-2000), tomj@communitychoice.org.

Inland Northwest in Charge Initiative, Health Improvement Partnership

Spokane and Eastern Washington

Overview

Inland Northwest in Charge is a collaborative project designing and financing a health care system for uninsured and underinsured individuals in Eastern Washington. Facilitated by the Health Improvement Partnership, more than 200 organizations and community members in Spokane and surrounding counties have participated in planning and implementation activities since 2000. Collaborators represent urban and rural populations and are from both the public and private sectors. They include hospitals, physicians, health plans, human service providers, chambers of commerce, employers, government agencies and health care analysts.

Goals

Year 2000 assessment and planning activities identified a series of priorities for regional health care system reform that include goals to:

- Increase outreach to and enrollment of eligible populations in state-sponsored health plans
- Design and market affordable "Expanded Choice" health insurance plans for those not eligible for state-sponsored health coverage
- Develop and implement care management pilots focusing on areas such as asthma, mental health, and individuals with multiple, complex health needs to improve patient outcomes and improve the cost-effective treatment of chronic illnesses
- Cultivate targeted health care access solutions in the areas of pharmaceuticals, dental care, and other identified needs
- Create improved patient referral protocols and clinical practice guidelines among hospitals and other providers
- Enhance information systems in an effort to: 1) improve data transfer among providers for the purposes of tracking patient outcomes and insurance eligibility and 2) increase access to telehealth and telepharmacy capacity (especially in rural areas)
- Integrate health and social service referrals through an online, searchable database and a centralized call center
- Design and implement policy initiatives that support these goals

Basic Description (see attached figure)

Inland Northwest in Charge (INIC) will act as a conduit and coordinator of health care access solutions through which more than half of the approximately 100,000 uninsured residents of Eastern Washington will receive sustained access to high-quality, comprehensive health care services. The INIC plan will unfold in three stages:

Stage One (2001): Accelerated enrollment using existing subsidies, linked to the development of a local resource pool

Stage Two (2002): Locally subsidized enrollment and care management, including "Expanded Choice" health plans and the incubation of regional care management system innovations

Stage Three (2003): Regional reconfiguration of the use of public health care dollars so as to extend access to the remaining uninsured

Target Population

The target population for this project includes uninsured and underinsured residents in an eleven-county region of Eastern Washington.

Financing

This project is funded through a three-year \$700,000 Robert Wood Johnson Foundation *Communities in Charge* grant, a one-year \$916,000 grant from the federal Health Resources and Services Administration (HRSA) Community Access Program, and other smaller grants.

Unique Features

The Initiative allows various health care stakeholder groups to collaborate in implementing the three-year plan and planning for longer-term sustainability. For example, a “cooperative financing” strategy would allow entities to donate savings to INIC. Policy strategies would restructure reimbursement to cover activities that emphasize education and prevention and reduce the need for and cost of acute services. The project’s Health for All program is currently developing an information system to track clients with chronic conditions.

Governance

In the initial planning stages of the initiative, a steering committee made up of a comprehensive cross-section of health care stakeholders in the Inland Northwest from both urban and rural settings guided decision-making. During implementation the steering committee has shifted to an advisory role. This group will eventually transform into a more formal Regional Healthcare Access Planning board to oversee the longer-term implementation of the INIC plan.

Initiative Status

January to March of 2002:

- Finalize “Expanded Choice” plans and marketing campaign
- Launch asthma pilot
- Analyze utilization and costs of people enrolled during 2001 using health plan data
- Work with state and other communities working toward increased access on policy strategies
- Begin to offer care “Expeditor”/care coordination services to the uninsured with multiple complex health and social issues
- Design referral protocols between hospital emergency departments and primary care clinics
- Continue to develop Regional Patient Index
- Implement primary care donated services model with private physician group

Contact

Dan Baumgarten, Executive Director, (509) 444-3088, Ext. 212, danb@hipspokane.org.

Inland Northwest in Charge (INIC) -- Policy Strategy Summary

<i>Focus</i>	<i>Legislature</i>	<i>Health Care Authority</i>	<i>DSHS/MAA</i>	<i>OIC</i>	<i>Governor's Office</i>	<i>WSHIP</i>
Triaging Access	Authorize locality to participate in activities that ensure seamless enrollment in state programs	Authorize locality to participate in activities that ensure seamless enrollment in state and other healthcare programs (such as determination of eligibility, processing applications and enrollments, access to eligibility systems, etc.)				
Coverage for the Employed Uninsured	Mandate pilot blending Basic Health, Medicaid, and Expanded Choice	Flexibility with Basic Health dollars, benefits and enrollment processes for individuals whose employer participates in Expanded Choice; Technical assistance and advice to planners; Participate in shared tracking of health outcomes and cost savings	Flexibility with Medicaid dollars, benefits and enrollment processes for individuals whose employer participates in Expanded Choice; Technical assistance and advice to planners; Participate in shared tracking of health outcomes and cost savings	Waivers to carriers in Expanded Choice (e.g., adjust mandated benefits); Provide technical assistance and advice to planners	Provide technical assistance and advice to planners	Create incentives for Expanded Choice participants to engage in disease management programs
New Services for Chronically Ill		Restructure reimbursement to cover strategies that emphasize education and prevention and reduce need for/costs of acute services; Provide use of information system to track clients with chronic conditions	Restructure payment to cover strategies that emphasize education & prevention and reduce need for/costs of acute services; Support locality in expanded No Wrong Door efforts; Provide use of information system to track clients with chronic conditions			
Local Subsidies	Allow plans and providers to collaborate among themselves and with each other; Allow entities to donate savings to INIC (based on revenues generated as a result of INIC)	Facilitate tracking of individuals enrolled via Health for All	Facilitate tracking of individuals enrolled via Health for All	Allow plans and providers to collaborate among themselves and with each other		
Cooperative Purchasing	Authorize state agencies to participate in a regional purchasing collaborative or to delegate purchasing decisions to local health planning authority for Eastern Washington	Participate in Eastern Washington purchasing collaborative	Participate in Eastern Washington purchasing collaborative	Allow carriers to work collaboratively in benefit package distillation process	Partner in strategies for startup foundation funding	Participate in Eastern Washington purchasing collaborative
Information Technologies		Participate in tracking INIC enrollee activity (utilization and costs); Allow access to Basic Health eligibility system	Participate in tracking INIC enrollee activity (utilization and costs); Allow access to MAA/DSHS eligibility system		Provide TA/ advice on patient privacy regulations	
Regional Planning Capacity	Authorize "Fast Track" for regional planning entities that meet readiness criteria	Creative planning and implementation of pilots with "Fast Track" communities	Creative planning and implementation of pilots with "Fast Track" communities	Creative planning and implementation of pilots with "Fast Track" communities	Creative planning and implementation of pilots with "Fast Track" communities	Creative planning and implementation of pilots with "Fast Track" communities

Jamestown S’Klallam Managed Care Program

Sequim, Washington

Overview

The Jamestown S’Klallam Managed Care Program provides access to health care, through the purchase of insurance, for all tribal members. The Tribe aims to use this program to provide higher quality care at less expense and to coordinate care for all members of the Tribe by maximizing the services they already have access to and filling in coverage gaps.

Goals

Four goals of the Jamestown S’Klallam program include:

- Coordination of existing health coverage
- Insurance for the uninsured
- Wrap-around services
- Coordination of preventive services

Basic Description (see figure below)

Target Population

The Jamestown S’Klallam Managed Care Program is designed to serve those living in the Tribe’s Contract Health Service Delivery Area (CHSDA) of Clallam and East Jefferson counties, as well as the 242 Tribal members.

Financing

The Jamestown S’Klallam Managed Care Program funding is provided through:

- Contract health service program funds from the Indian Health Service (IHS) through a P.L. 93-638, Title III Self-Governance Compact (98 percent)
- Profits from tribal businesses and a small Medicaid administrative match (2 percent)

Unique Features

The Jamestown S’Klallam Managed Care Program provides wrap-around services for those who are insured on a case-by-case, pre-authorized basis, and pays the member’s premium for private employer-sponsored coverage and Medigap coverage.

Governance

The Jamestown S’Klallam Managed Care Program is governed by the Tribe through the Tribal Self-Governance program. This governance structure involves a broad cross-section of the community through provision of coverage for all Tribe members (242 members).

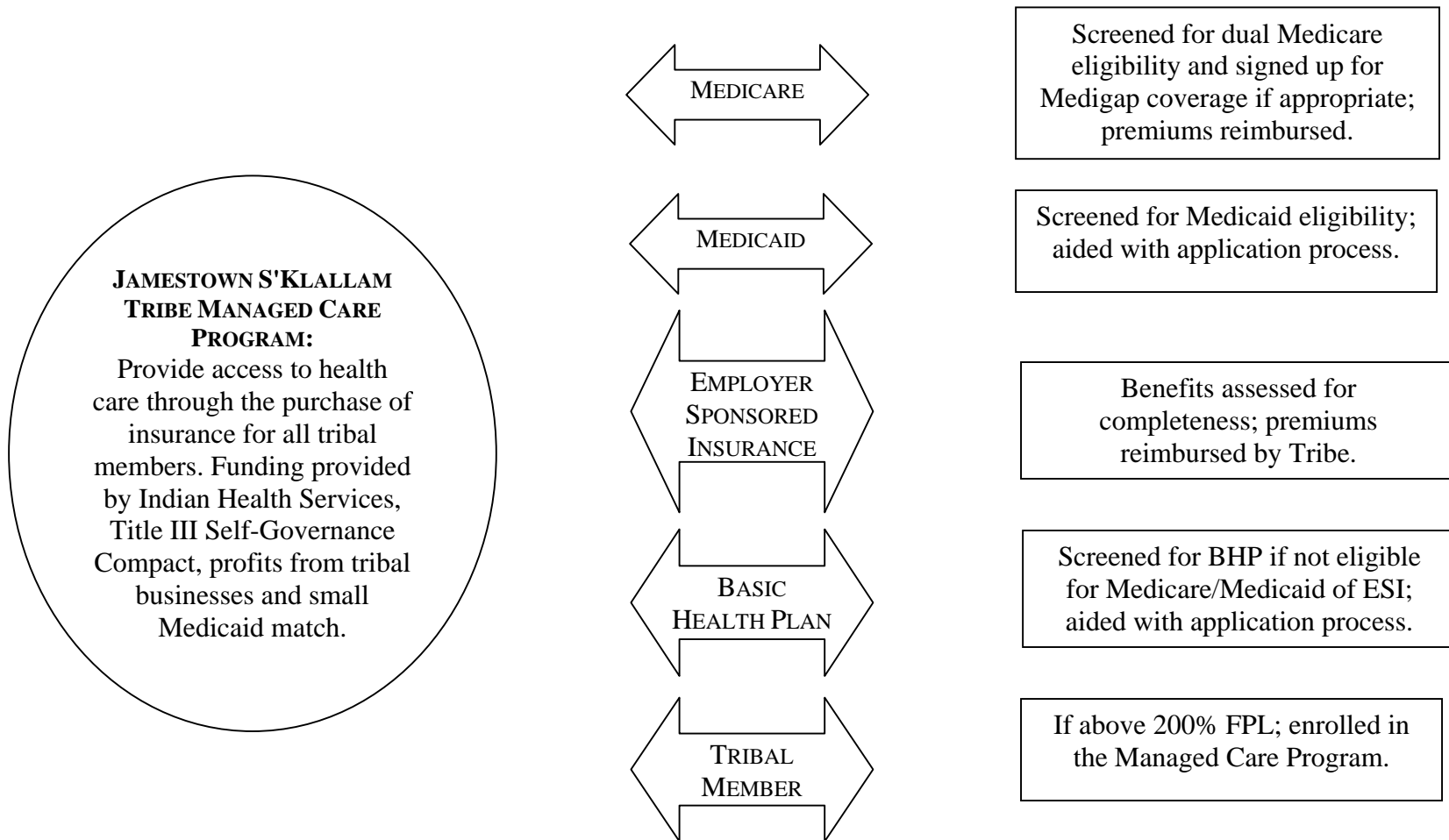
Initiative Status

This program is being implemented by the Tribe.

Contact Information

Vicki Lowe, 360-683-1109, www.jamestowntribe.org.

Jamestown S'Klallam Tribe Managed Care Program



All tribal members are provided with wrap around services, such as prescription drugs, vision, dental, durable medical, and preventative services if not provided by other sources.

Kids Get Care, King County Health Action Plan

King County, Washington

Overview

Kids Get Care is designed to link children to a health care home for prevention and general care, regardless of their health insurance status. The program is sponsored by the King County Health Action Plan, a partnership of public and private organizations whose mission is to mobilize resources in King County to improve health through system integration, mutual responsibility, and effective strategies. Kids Get Care grew out of a concern that many children were not receiving basic health care service despite expansions of public health insurance programs, as well as a desire to improve children's health status through an early focus on prevention.

Goals

The goal of Kids Get Care is to ensure that children aged 0-5 receive a basic level of health care services that includes physical, oral, and developmental health. The program hopes to screen 5,000 children, refer 3,000 children to hubs for linkage to a health care home, and train 100 health care providers and community organization staff how to screen children. In addition, the program seeks to provide dental services to about 15,600 in a total of 10 sites over the next three years.

Basic Description

The program has developed three "hub" sites in communities with high concentrations of uninsured and underinsured children who are being linked to the hubs through established community-based organizations (CBO). The hubs include Community Health Centers of King County's Kent and Eastside Clinics and Odessa Brown Children's Clinic and Carolyn Downs Family Medical Clinic at the Central Area Health Care Center. Kids Get Care will train local health care providers and CBO staff how to screen for important indicators of physical, oral, and developmental health.

Target Population

The target population for Kids Get Care includes approximately 5,000 children, whom the program hopes to screen in the three hub sites.

Financing

The Kids Get Care initiative is funded by a one-year (September 2001-August 2002) Community Access Program grant from the federal Health Resources and Services Administration. In addition, a three-year Washington Dental Service Foundation grant will allow the program to expand its oral screen, prevention, and care services. The program will seek continuation funds and, in the longer term, sustainable financing within each target community.

Unique Features

Kids Get Care is an effort to go beyond obtaining insurance coverage for children to connecting them with needed services, regardless of their eligibility for, or enrollment in, existing insurance programs.

The organization of the initiative is focused on specific, defined communities and health care providers that have track records in serving lower income, hard-to-reach populations.

Governance

Kids Get Care is an outgrowth of the King County Health Action Plan. The Health Action Plan is coordinated through Public Health-Seattle & King County, and a volunteer steering committee of public and private sector leaders provides oversight to its many activities.

Initiative Status

The program has established the three hub sites, hired central program and site staff, identified CBOs in each hub community, and begun recruitment of health care providers. In addition, a new tracking system is being used at all sites, and staff in some of the organizations have been trained in screening techniques.

Contact Information

Lisa Podell, Kids Get Care Program Coordinator, (206) 296-2780,
lisa.podell@metrokc.gov/health.

NorthEast Washington Medical Clinics

Northeastern Washington

Overview

The overall purpose of NorthEast Washington Medical Clinics (NEWMC) is to formalize the interdependence between the hospital, physician group, and the communities they serve for the purpose of ensuring the long-term sustainability of the area's health system.

Goals

The goals of the NEWMC are to:

- Maximize volume of services
- Develop collaborative services
- Provide expert management and information systems
- Provide quality medicine
- Promote long-term growth of health care services
- Encourage competitive compensation
- Collaborate with other community resources to provide a mechanism for identifying the health care needs of the community
- Attain and sustain financial viability of the network
- Recruit and retain the appropriate complement of physicians and staff to provide the health care needed by the community
- Implement a clinical effectiveness program that maintains quality and cost effectiveness of services provided
- Serve as an education resource for health care professionals and the community
- Ensure compliance with regulatory requirements

Basic Description

Colville Medical Group and Mt. Carmel Hospital have agreed to create the NorthEast Washington Medical Clinics, a not-for-profit corporation formed to conduct the business and contracting side of outpatient ambulatory care in a rural clinic setting. Ancillary services will include medical laboratory, pharmacy, and occupational medicine services. The clinic will contract for multi-specialty medical services from NorthEast Washington Medical Group (NEWMG), a multi-specialty physician group. Mt. Carmel Hospital is a licensed 55-bed facility with approximately 28 active beds. The hospital has two operating rooms, eight ICU/CCU beds, radiology (includes CT), ultra-sound, and mammography. These organizations have decided to integrate their operations through a not-for-profit model. This model was based on successful models reviewed during the initial integration evaluation.

Target Population

The NEWMC is designed to serve residents of North Stevens, Pend Oreille and Ferry counties (The city of Colville has approximately 5,000 residents. The surrounding areas comprise another 25,000 to 30,000 people). Stevens, Pend Oreille and Ferry counties rank 37th, 38th, and 39th, respectively, out of the state's 39 counties for per capita income. The entire service area has been designated either as a geographic or population health professional shortage area.

Financing

The NEWMC/NEWMG are primarily funded through fees charged for providing medical care. In addition, NEWMC/NEWMG and Mt. Carmel Hospital have applied for HRSA and Washington Health Foundation grants. Following 501(c)3 designation, NEWMC will be able to solicit, receive, and administer additional grants.

Unique Features

NEWMG and NEW Health Programs are studying co-locating a community health center in the clinic in Colville, which should help to coordinate care for low-income individuals.

The NorthEast Washington Medical Group has recently been designated as a Rural Health Clinic by the federal government for both its Colville and Kettle Falls offices, allowing it to receive special “reasonable” cost reimbursement from Medicaid and Medicare for services.

The NEWMG has a special focus on telemedicine due to its physically isolated location.

Governance

The NEWMC board will be composed of eleven members, including four physicians from the NEW Medical Group, four representatives of Mt. Carmel Hospital, and three community members.

Initiative Status

The NEWMC not-for-profit model has been approved by NEWMG and Providence Services of Eastern Washington pending review of final formation documentation and is in development and subject to change.

Contact Information

Ron Rehn, CEO, 509-684-3701, rrehn@newmg.org, <http://www.newmg.org/>.

100% Access Project, CHOICE Regional Health Network, Central, Western Washington

Overview

CHOICE Regional Health Network is a not-for-profit consortium dedicated to improving the health of people who live in the service area of central, Western Washington. One of its goals is to develop, advocate and implement a demonstration project that provides “100% Access” to health care for the residents in their service area.

Goals

The goals of the 100% Access Program are to:

- Provide access to a uniform set of covered services within a coordinated system that is easy to access and navigate. The target population will have timely and barrier-free access to a set of community-prioritized health services.
- Implement a model that coordinates funding and programs to serve as a model health care system that holds individuals, providers, and other participants accountable for improving community health outcomes.
- Sustain providers' ability to care for consumers in ways that maximize their patient's health and provide them with appropriate and timely reimbursement.

Basic Description (see attached figure)

The 100% Access Program will bring physicians, hospitals, and others together to design a sustainable health care system by using a community-led design process for mutual learning and decision-making among consumers, practitioners, and the state. The project will identify and implement short-term survival strategies while designing longer term solutions using model options evaluated based on community-decided criteria.

Target Population

CHOICE defines its community as the residents of Grays Harbor, Lewis, Mason, Pacific, and Thurston counties—central Western Washington—totaling 428,000. The specific target population is 93,000 residents who have incomes below 250% of the federal poverty level. Half of this target group is uninsured, and the other half is enrolled in state-subsidized insurance.

Financing

CHOICE Regional Health Network received one of four HRSA Community Access Program (CAP) grants to be funded over a five- to seven-year period to design a community-based 100% Access demonstration project. The Network also receives dues from local members and grants from other sources, including the Washington Health Foundation.

Unique Features

CHOICE serves as a catalyst for the community to identify current problems, desired outcomes of a re-designed system and criteria to evaluate model options. The community contributes ideas and other resources through town meetings, surveys, interactive Web sites, outreach activities, and public events.

Governance

CHOICE is a nonprofit mutual corporation with several types of membership, including sustaining, associate, and affiliate members who are either individuals or organizations that may pay dues, provide in-kind resources, serve on the Board of Directors, or provide voluntary technical assistance or consultation. The 100% Access Project is governed by a Sustainable Healthcare Access Council comprising community leaders and state government technical advisers.

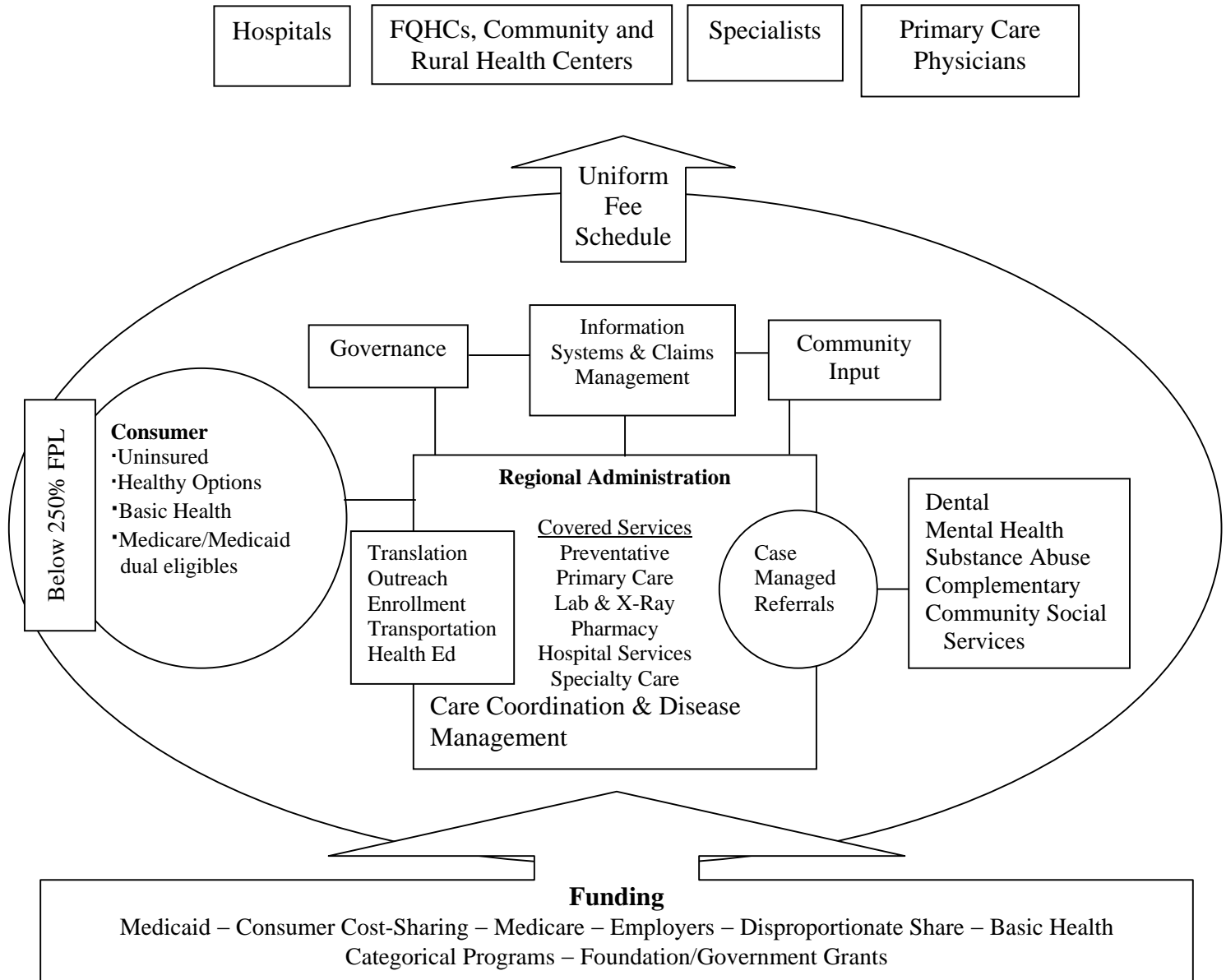
Status

The 100% Access Project is currently in the design and implementation phase. The activities include program enrollment and case management system improvements to integrate the application process among state programs, the identification of complex cases, and business plan development. Early deliverables include a care coordination pilot project and HIPAA assistance for small hospitals and group practices.

Contact Information/ Website

Kristen West, Executive Director, (360) 493-4550, westk@choicenet.org, www.choicenet.org.

100% Access Project, CHOICE Regional Health Network



Rural Health Reform Workgroup

East Jefferson County, Washington

Overview

Commissioners of Jefferson County Public Hospital District #2 and the Jefferson County Board of Health have been meeting to discuss problems related to access to health care for residents of East Jefferson County. A workgroup of various stakeholders, sponsored by the two organizations, met to discuss potential solutions and organize a Health Access Summit held in March 2001. Additional discussions have followed. The focus of the workgroup is improving health, ensuring access to needed health and social services for all residents, supporting financially strong and sustainable local providers, promoting high-quality services, and encouraging efficiency through greater coordination and less duplication of services.

Goals

The goals of the Rural Health Reform Workgroup are:

- Access to care: Broad range of services will be available to East Jefferson County (EJC) residents, particularly the most financially and physically vulnerable.
- Quality of care: Quality will continually be improved.
- Funding sources: Funding sources will be organized to better support the local health care system.
- Spending impacts: System funding will be directed to improve the health and quality of life of EJC residents.
- Medical practice viability: EJC providers will be supported by the community to ensure the continued availability of their services.
- Incentives to improve health: Prevention and public health are important components of the model.
- Administrative functions: A local, publicly accountable entity will manage administrative functions in a way that improves access, reduces complexity, supports local health services, and redirects as much funding as possible to direct services.
- Patient autonomy: Patients should have the greatest range of choices within our financial limits.
- Physician clinical decision-making autonomy: Cost containment and clinical autonomy will be balanced through quality improvement activities.
- External factors: External factors (e.g., state funding, policy changes) will be continually monitored to take advantage of beneficial developments and address disadvantageous changes.
- Future demographic factors: Health system changes should be designed to accommodate the changing demographics and needs of the EJC population.
- Personal responsibility: Incentives should be built into the system to encourage individuals to take personal responsibility for their health and the services they need.
- Occupational support: System will incorporate special programs and services that will help impaired and disabled EJC residents maintain or regain physical functioning to participate as members of the local workforce and community.

Basic Description

The summit identified the following problems with the current health system:

- Health care financing system is broken.
- Uninsurnace levels are rising and consumers cannot pay out of pocket costs.
- State budget problems.
- Current financial incentives are determined by the insurance companies and focus on treating the sick rather than on community health promotion.
- Administrative burden of health plans is increasing.
- Lack of state or federal leadership to solve problems disproportionately affects rural areas.

Financing

The workgroup received a grant from the Washington Health Foundation and used local resources to provide staff support to the process.

Target Population

All residents of East Jefferson County are served by this workgroup.

Governance

This process is sponsored by a partnership between the public hospital district trustees and the board of health.

Status

Community discussions are ongoing.

Contact Information

Kris Locke, Project Consultant, (360) 683-9152, thlocke@aol.com.

Arkansas River Valley Rural Health Cooperative

Northwest Arkansas

Overview

The purpose of the Arkansas River Valley Rural Health Cooperative is to provide access to health care for working uninsured and underinsured non-elderly adults, regardless of income level.

Goals

The Cooperative aims to:

- Provide comprehensive health care through the provision of basic health care services through a network of local providers
- Provide comprehensive health care through supplemental provision of catastrophic coverage
- Achieve coverage of 50 percent of non-elderly uninsured (about 3,000 people)

Basic Description (see figure below)

Target Population

The Arkansas River Valley Rural Health Cooperative is designed to serve a three-county area (Franklin, Logan, and Scott counties) with a population of 45,000. It specifically targets the non-elderly uninsured population, roughly 6,000 individuals.

Financing

Funding for the Arkansas River Valley Rural Health Cooperative is provided by:

- Membership dues, which operate on a sliding-fee schedule and comprise about 40% of the budget
- The Membership Subsidy Fund derived from federal and state funds, as well as from private contributions from supporting members (about 60%)

Unique Features

The cooperative is not an “insurance product.” There are three types of membership: provider, client, and supporting members.

Governance

The Arkansas River Valley Rural Health Cooperative uses an “extended partnering” concept of governance, whereby the federal and state governments, local communities, local health care providers, and individual plan members all share cost, benefits, risk, and responsibility for the plan.

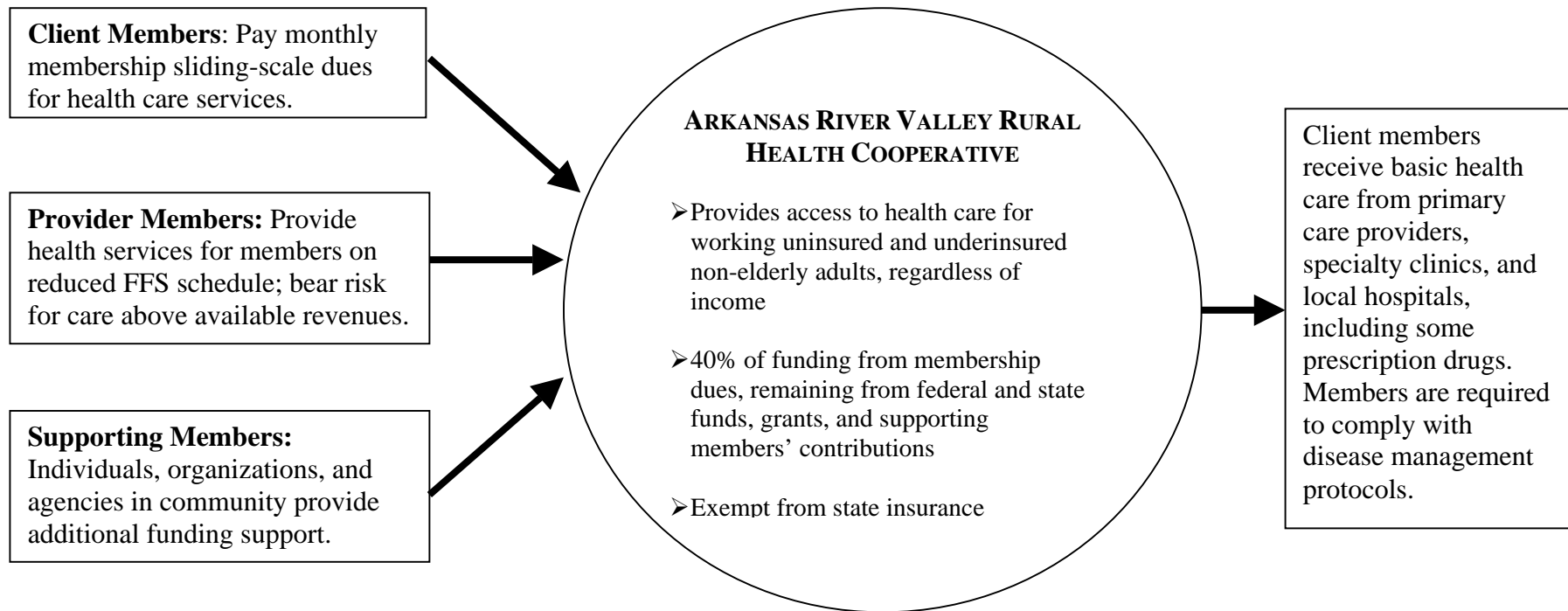
Initiative Status

This initiative is currently being implemented.

Contact Information

M.R.(Bob) Redford, Executive Director, (501) 635-4400

Arkansas River Valley Rural Health Cooperative



Rural Wisconsin Health Cooperative

South, Central Wisconsin

Overview

The purpose of the Rural Wisconsin Health Cooperative (RWHC) is to serve as a catalyst for regional action, to support and enhance rural health and quality of care, and to work cooperatively to maximize community-controlled services.

Goals

The goals of the Rural Wisconsin Health Cooperative include:

- Advocate for rural health
- Provide clinical/management products and services tailored to the needs of individual members
- Negotiate collaborative managed care contracts

Basic Description (see figure below)

Target Population

The Rural Wisconsin Health Cooperative is designed to serve 28 rural acute, general medical-surgical hospitals located in south central and mid-state Wisconsin and the communities they serve. This program includes no specific outreach for uninsured or underinsured.

Financing

The Rural Wisconsin Health Cooperative is funded by:

- Revenues from products and services supplied to members (about 90 percent)
- Membership dues (5 percent) and grants (5 percent).

Unique Features

The cooperative respects the autonomy of the sponsors. The Rural Zone of Collaboration Initiative has given rural providers access to management services such as credentialing and data collection that will help them comply with administrative audits. RWHC administers a federal Outreach Grant for three county health departments and five rural hospitals. RWHC is one of three governing organizations of Unity Health Plan, a local HMO.

Governance and Community Involvement

The Rural Wisconsin Health Cooperative is owned and operated by 28 rural acute, general medical-surgical hospitals. The cooperative maintains a close working relationship with Community Physician Network, the area's IPA.

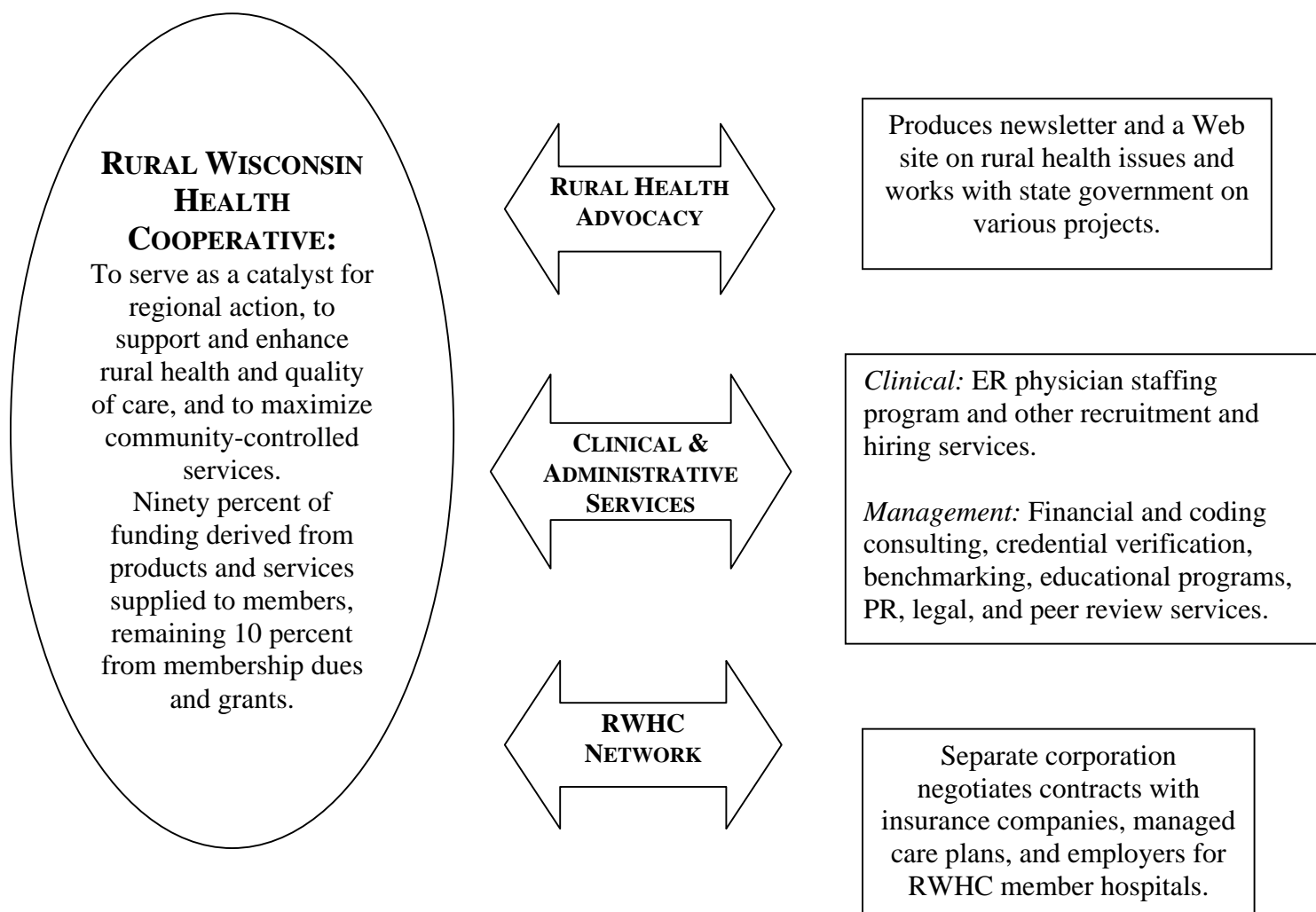
Initiative Status

This initiative is currently being implemented.

Contact Information

Larry Clifford, (608) 643-2343, www.rwhc.com.

Rural Wisconsin Health Cooperative



Appendix C

Community Access Initiatives Needs Assessment

Barriers to and Opportunities for Community-State Partnerships to Improve Access As Reported by Representatives of Selected Community Access Initiatives (December 2001)

	Barriers to state partnership perceived by communities	Types or areas of technical assistance or partnership communities might seek from the state	Administrative, regulatory, or legislative changes or flexibility that might support community access initiatives
Community Access Initiative #1	<p>The state's approach to health care purchasing is fragmented and doesn't consider how publicly supported programs affect each other or how purchasing affects vulnerable, essential community providers.</p> <p>The state has destabilized many rural health systems through managed competition purchasing strategies, because rural areas are too small to support competition. The state is also unwilling to take risk and condones plans cutting provider payment to rates below the cost of providing service.</p> <p>State agencies don't acknowledge that the health care financing system is broken.</p> <p>State agencies and key decision-makers have focused on urban issues at the expense of rural health systems and providers.</p> <p>Public programs (and their managed care plans) place a heavy paperwork burden on providers.</p> <p>The state levies B&O tax on providers even if they lose money.</p> <p>The state's Physician Integrity program (Medicaid audits) is onerous and offensive given what providers are paid.</p> <p>The client application for BH has become too complicated and long—creating a barrier for some populations.</p> <p>The state treats providers as vendors, not as partners in serving people.</p> <p>Executive or legislative leadership to find solutions to these worsening problems is lacking.</p>	<p>The state (e.g., the OIC) should be responsive to local proposals that may require different ways to provide health insurance coverage.</p>	<p>The federal Health Professional Shortage Area program allows the governor of a state to designate HPSAs outside of the normal guidelines. Gov. Locke should designate all rural areas as HPSA, which would reduce administrative burdens and streamline the designation processes for programs such as RHCs.</p> <p>Change the health professional loan repayment program so a HPSA does not have to renew the paperwork every year.</p>

	Barriers to state partnership perceived by communities	Types or areas of technical assistance or partnership communities might seek from the state	Administrative, regulatory, or legislative changes or flexibility that might support community access initiatives
Community Access Initiative #2	<p>State purchasers continually ask providers to do more with less (e.g., new Healthy Options PCCM proposal). HCA does not monitor its contracts with health plans regarding provider satisfaction.</p> <p>State purchasers prefer to reduce payments to and increase burdens on providers rather than cut eligibility or services, expecting providers to keep playing along.</p> <p>State purchasers do not keep payments current and use out-of-date forms and methods of patient identification.</p> <p>L&I claims managers have barriers to communicating with their medical directors.</p> <p>Credentialing complexity delays payment and sometimes prevents new providers from seeing patients as soon as they could.</p> <p>The state, in general, is not sufficiently knowledgeable about the problems at the local level (as DOH is).</p> <p>State views providers as slaves not partners.</p>		
Community Access Initiative #3	<p>State rules and laws—including those regarding ethics, conflicts of interest, competitive bidding, public meetings, public disclosure, use of public funds for private gain, and HIPAA—appear to be used sometimes as excuses for not being active or proactive.</p> <p>State agency staff are often unresponsive, uninformed about local conditions, and unwilling or unable to fulfill commitments.</p> <p>Information and guidance from HCA and MAA are often inconsistent, suggesting a lack of unified leadership.</p> <p>The dichotomy between MAA and BHP means the state does not maximize available federal funds.</p> <p>The state is reluctant to enter into partnership with communities for fear of seeming to play favorites, but quite willing to form cozy relationships with health plans.</p> <p>The state seems to prefer uniformity across the state, a one-size-fits-all approach. The federal government is more supportive of local innovations.</p> <p>MAA and HCA view their mission as contracting with</p>	<p>The state should redefine its relationship with local initiatives and providers from "vendor" to "partner" (see Attachment D, "Partnership with the State: What Does It Mean to Partner?").</p> <p>State staff—across all agencies—should receive clear, consistent guidance about what they can and can't do under state rules and laws.</p> <p>Refocus state policy on access to services rather than health plan contracting; set goals, and be accountable for them.</p> <p>State staff should become active participants in the development, implementation, and governance of the four CAP community initiatives.</p> <p>State government should work with community initiatives to develop cooperation agreements that formalize partnership relationships, including points of mutual accountability.</p> <p>Appropriate staff from MAA and HCA should rotate through the organizations that coordinate community access initiatives to expand their</p>	<p>The state should merge the management of Medicaid and Basic Health programs to reduce administrative complexity and duplication.</p> <p>HCA should pay organizations that conduct client outreach as MAA does.</p> <p>The state should create a clear process for waiving state requirements for the purpose of allowing communities to experiment with system reform.</p> <p>HCA and MAA should consider alternative contracting arrangements, such as DOH's consolidated contracts with local health departments, USAID Cooperative Agreements, or (in the case of public hospital districts) intergovernmental agreements.</p> <p>Use smart card technology to simplify eligibility processes, much as DSHS does within the food stamp program.</p> <p>Create a single point of entry and a single</p>

	Barriers to state partnership perceived by communities	Types or areas of technical assistance or partnership communities might seek from the state	Administrative, regulatory, or legislative changes or flexibility that might support community access initiatives
Community Access Initiative #3 [continued]	<p>health plans, not access for clients.</p> <p>State agencies / staff are comfortable with vendor relationships but not with partnerships. They don't seem to see providers as important <i>clients</i>.</p> <p>Staff are reluctant to participate in local initiatives in decision-making roles, perhaps so they can avoid committing to any particular direction.</p> <p>Categorical funding and programs create duplicative and complex fiefdoms.</p> <p>Low provider payment and high administrative burdens challenge providers' commitment to serving low-income patients.</p> <p>The state does not acknowledge that the health plan contracting strategy is not working in some or many communities.</p> <p>Dental Health</p> <p>Some individuals in MAA are dedicated to dental health, but that is not true agency-wide.</p> <p>Don't cut adult dental; why would the state consider doing that, given the surgeon general's report?</p> <p>Generally too many barriers to getting paid.</p>	<p>knowledge of what happens "on the ground."</p> <p>State agencies and the governor's office should involve representatives of community access initiatives in state health policy decisions.</p> <p>Leadership in and accountability for state health policy should be focused in one state agency or in the Governor's office.</p> <p>The state should find ways to share more data with local community initiatives and local providers, which will allow for better tracking of and assistance to individuals and families.</p> <p>The state should communicate directly with providers more often, not just rely on health plans. For example, the state could disseminate information to physicians about categories of drugs for which spending is very high and promote the use of low-cost drug alternatives.</p> <p>MAA and HCA should better monitor health plans to assure high service standards and efficient administration, not just network adequacy.</p> <p>Dental Health</p> <p>Allow retired dentists to provide care to low-income individuals—need to ensure they have malpractice insurance and up-to-date skills.</p> <p>Find a way for a community to use savings (e.g., for innovative projects) from the difference between what the state pays for inpatient and outpatient care, if the community finds ways to substitute latter for the former.</p> <p>Fund an oral health coordinator in each community, as DOH does with MCH funds in 13 counties.</p> <p>Improve access for communities to information about state health programs.</p> <p>The state should be willing to match community-generated resources for innovating projects.</p>	<p>application process for those applying for BHP or Medicaid.</p> <p>Pay providers for the role of being "medical homes."</p> <p>Establish an ombudsman office to work with community access partners.</p> <p>Put the agencies' medical directors in a more central role in working with practice and clinical issues.</p> <p>Consider pooling multiple funds and programs in order to reduce administrative complexity and duplication. For example, combining various Medicaid programs could help to reduce the as many as six case managers a Medicaid FFS client can have.</p> <p>Dental Health</p> <p>Advocate with the federal government to increase the match rate for the ABCD program.</p>

	Barriers to state partnership perceived by communities	Types or areas of technical assistance or partnership communities might seek from the state	Administrative, regulatory, or legislative changes or flexibility that might support community access initiatives
Community Access Initiative #4	<p>It is difficult to get to “command central” at MAA and HCA; that is, to find the right person who is in a position to discuss and develop potential partnerships.</p> <p>State agency staff meet requests or questions with simple yes-no answers rather than seeing the inquiry as a jumping off point for discussion.</p> <p>State agencies appear to fear that discussions with one community may lead to adverse effects for other communities, so they are disinclined to begin the discussions.</p>	<p>Work with local initiatives to pilot care and disease management models for people with chronic illnesses who are not otherwise served by the existing system.</p> <p>Create a mechanism and criteria that would “fast track” partnership discussions between “ready and able” communities and the state.</p> <p>Provide technical assistance and advice on patient privacy regulations.</p>	<p>Allow local initiatives to determine or at least track eligibility, enrollment, and re-enrollment for BH and Medicaid, as if it was a local office of the state.</p> <p>Commit to criteria within which localities/ regions may launch pilots that test new models for expanding health care access. These criteria include conditions under which public health care dollars may be used in new ways in conjunction with localities’ projects.</p> <p>Waive OIC rules that insurance products include state-mandated benefits for health insurers participating in HIP’s Expanded Choice initiative (to help employers to sponsor coverage for their employees).</p> <p>Allow local initiatives to use Medicaid and BH funds to subsidize employer-sponsored coverage.</p> <p>Authorize state agencies to participate in an Eastern Washington purchasing cooperative (a nascent idea at this point).</p>
Community Access Initiative #5	<p>The state does not provide information to community groups for those people they enroll in BHP, Medicaid, and CHIP (e.g., name, date of services, provider of services, charges, payments).</p> <p>An adjudication program (for accepting risk contracts) is prohibitively expensive.</p> <p>Medicaid’s payment integrity program is a burden and distraction and is unnecessary.</p> <p>The special status afforded CHPW has the effect of limiting access to health care, because: 1) other carriers cannot compete with CHPW and so leave the area and 2) low payment rates from other payers have led to providers leaving for better business environments.</p>	<p>The state could provide timely data about state clients who community groups help to enroll in BH, Medicaid, and CHIP so communities can better monitor and target their efforts.</p> <p>The state could provide assistance in HIPAA implementation.</p> <p>Medical directors in state agencies should take the lead in developing care management strategies and policies in partnership with providers and community organizations.</p> <p>The state should partner with community access initiatives to help these organizations leverage resources from private foundations.</p> <p>The state should establish standards for service efficiency and quality to promote accountability for results.</p>	<p>The state should drop the payment integrity program.</p> <p>The state should pay providers, especially rural providers, more fair and responsible rates.</p> <p>The OIC should hold all risk-bearing entities to the same insurance standards, including community clinics [CHPW].</p> <p>Avoid unfunded mandates.</p> <p>The state should implement direct contracting, with some risk-sharing by the state (e.g., reinsurance).</p>

Appendix D

Partnership with the State: Definitions

*What does it mean to partner?**

Definition of Partnership: A relationship existing between two or more people or organizations invested in each other's successful movement towards a common goal. Partners are joined together in a mutually responsible relationship involving close cooperation among people who commit to learn from each other and agree on the actions to be taken for mutual benefit.

Definition of Vendor: One that vends (sells) products or provides service(s) by formal binding structures such as: Letters of Agreement, Contracts, RFPs, Cooperative Agreements, etc.

Characteristics of Partnership vs. Vendor Relationships:

Partnership	vs.	Vendor
<ul style="list-style-type: none">• Work together to design product or service.• Ongoing discussions about mutual concerns and opportunities to meet a common goal.		<ul style="list-style-type: none">• Contractual arrangement to sell a product ("as is") or provide a service to government, which has not been jointly designed.• Alignment of organizational goals is not required.
<ul style="list-style-type: none">• Shared decision-making.• Interactive in developing mutual responsibilities and outcomes.		<ul style="list-style-type: none">• Set responsibilities defined in contracts that aren't negotiable.• Predetermined outcomes.
<ul style="list-style-type: none">• Joint development of ideas in an open and inclusive way.		<ul style="list-style-type: none">• Ideas developed in isolation and approved or denied through a strict and closed RFP contracting process.
<ul style="list-style-type: none">• Shared resources tailored to project.		<ul style="list-style-type: none">• Confidential and competitive RFP process with statewide uniformity.
<ul style="list-style-type: none">• Collaborative approach trying new approaches.• Learning/adjusting without blame or punishment for unintended outcomes.		<ul style="list-style-type: none">• Mature products and services (status quo) tend to successfully compete for contracts.• Incentive to highlight successes and hide failures in order to keep contract rather than learn and self-correct.
<ul style="list-style-type: none">• Evaluation of projects to enhance mutual learning and adjust goals and approaches.		<ul style="list-style-type: none">• Evaluation to award funding or withdraw contracts.
<ul style="list-style-type: none">• Share risk for experimentation.• Seek solutions together.		<ul style="list-style-type: none">• Pass risk downward (sink or swim) to vendors.
<ul style="list-style-type: none">• Support one another in setting priorities.• Honest discussion of "value."		<ul style="list-style-type: none">• Priorities are set by government and vendors bid for the business.• Lowest bidders are usually selected.

* Developed by CHOICE Regional Health Network.